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ABSTRACT

Part of a study of migrant child welfare services, this review synthesizes all available materials on the issues affecting migrant child welfare. Each chapter discusses the importance of a particular service area, assesses the migrant child's needs in that area, describes existing barriers to service delivery, and presents a history and the current status of legislation and programs affecting the services. Services are in the areas of physiological and environmental health, education, day care, child abuse and neglect, and legal aid. These include services targeted specifically to migrant children as a unique population and services available to them as part of the general population. Among the topics are: the 1962 Migran Health Act; Food Program for Women, Infants and Children; Food Stamp Act; National School Lunch and Child Nutrition Act; Social Security Act; family structure; child labor; Fair Labor Standards Act; laws regulating wages, unemployment, right to organize and bargain collectively; Pesticide Protection Laws; housing; Occupation Safety and Health Act; mental health; ESEA Titles I and VII; Comprehensive Employment and Training Act; Emergency School Aid Act; California Migrant Teacher Assistant Mini-Corps; Learn and Earn; New York State Migrant Center; Migrant Head Start; illegal aliens; Texas Migrant Council Child Abuse and Neglect Prevention Program; and legal aid. A 301-item bibliography of materials collected is included. (NQ)

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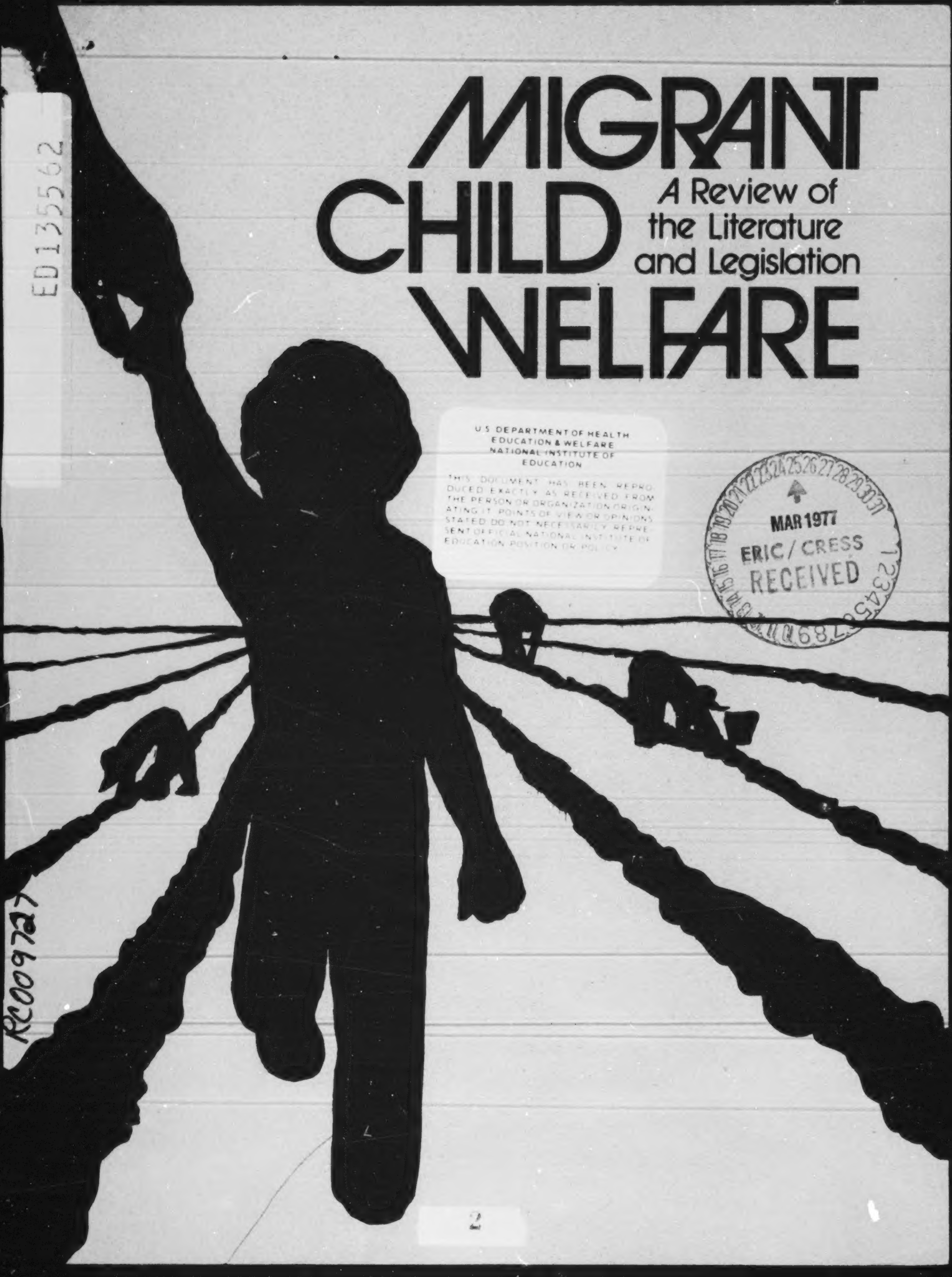
MIGRANT CHILD WELFARE

A Review of the Literature and Legislation



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A State of the Field Study of Child Welfare Services for Migrant Children and Their Families Who are In-Stream, Home-Based, or Settled-Out

Literature Review

by

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The content of this review does not necessarily reflect or represent the views of the Department of Health, Education, and Welfare and are solely those of the author and InterAmerica Research Associates.

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INTRODUCTION

This review is part of a study of migrant child welfare services and is funded by the National Center on Child Advocacy of the Office of Child Development, Department of Health, Education, and Welfare. The project is being conducted by InterAmerica Research Associates and will report on the status of migrant child welfare as determined through interviews with migrant families, migrant advocacy agencies, and other public service agencies. The purpose of this review is to synthesize all available materials on the issues affecting migrant child welfare, and in doing so it will serve as a background for other aspects of the study.

The goals and objectives of child welfare services, as described by the Office of Child Development, include providing supportive and supplemental services to families and children, preventing the separation of children from their families and improving the delivery of preventive, supplemental, and substitute care. Traditionally, the specific services proposed to meet these goals include adoption and foster care, residential treatment, institutional care, homemaker services, protective services, etc. However, child welfare is defined broadly in this review to encompass more then the traditional child welfare services. This is because the needs of migrant children are very basic. Most migrant children suffer from the effects of inadequate food, clothing and housing; therefore, the need for services such as foster care, institutional care, residential treatment, becomes less urgent. Additionally, many of the traditional child welfare services are not as appropriate for the the migrant population. For example, extended families and close friends or neighbors will more frequently care for a child who otherwise would need adoption or foster care services.

For these reasons, the goals of child welfare when applied to migrant families must first be met by supporting the family with supplemental services such as day care, food supplements, health care, emergency aid and education. These basic services will help improve their immediate and future economic and social well-being. At present, it is these basic needs which, if met, will have the greatest impact on the well-being of the migrant child. Thus, the services in this review will be in the areas of physiological and environmental health, education, day care, child abuse and neglect, and legal aid. This will include services targeted specifically to migrant children as a unique population and services available to them as part of the general population.

Each of the following five chapters discusses the importance of a particular service area, assesses the migrant child's needs in that area, and describes existing barriers to service delivery. In addition, a history and the current status of legislation and programs affecting the services is presented.

Written material on migrant child welfare is extremely limited. In writing this review both published and unpublished manuscripts were used, the majority of which were written within the last ten years. Additionally, a number of published bibliographies were consulted. Several computer searches were performed for this review by the National Clearinghouse for Mental Health Information, National Health Planning

Information, Smithsonian Science Information Exchange, Educational Resources Information Service, Technical Information on Projects System, and the Congressional Research Service. Also, relevant legislation was collected as well as transcriptions of Congressional hearings dealing with migrant farmworker issues. Further information came from specific local, county, state, and federal programs which influence or have the potential to influence the migrant child's well-being.

Interviews were conducted with relevant federal agency personnel, farmworker organizations and professionals working with migrant families. Some information collected during the site visits conducted for the final project is also included.

To date there has been no comprehensive study of migrant children because of the diversity of this population and the great difficulties encountered in collecting the necessary data. Estimates of the size of the migrant farmworker population range from 600,000 to 1,000,000 nationwide.[1] According to the Office of Education, there are more than 450,000 migrant children in need of services. The migrant population includes several different cultural backgrounds. The majority are Mexican Americans, while Blacks make up the next largest group. Smaller numbers of Whites, Indians, Filipinos, Puerto Ricans, and Canadians are also represented. Most of these workers are very young; over 60% are under 25 years old. Migrant family size tends to be fairly large, with an average of 5.4 members.[2]

Migrant farmworkers travel in three major streams when working "on the season." The east coast stream moves from Florida northward to New York with some families entering the New England states. Florida is the major home base state and the migrant population is predominantly Black with a growing number of Chicanos. The mid-continent stream stretches from Texas northward through the midwestern states to Michigan. This stream consists mostly of Mexican American workers. The west coast stream includes the large home base state of California from which workers travel north to Oregon and Washington. This stream is also primarily Mexican American.

This yearly migration and the variety of racial and cultural backgrounds make the migrant population unique. These characteristics also make traditional child welfare service delivery inaccessible and inappropriate for their needs. Specifically, it is the lack of continuity of services due to their constant mobility, the lack of cultural understanding, and the language differences that act as major barriers to their receiving services.

CHAPTER I

HEALTH AND NUTRITION

Health and nutrition have major and lasting effect on the well-being of any child. Poor health at any time of life affects emotional, cognitive, and physical growth and welfare. Young children, especially those under three years, are particularly vulnerable to the adverse effects of poor health and nutritional deficiencies since this is the most critical stage in their development. Good, consistent, and accessible medical care is essential to prevent children from being born at a disadvantage and then not reaching their full human potential throughout childhood.

The migrant child is at a particular disadvantage, due not only to poverty but also to geographic and ethnic barriers.[1] The migrants' livelihood depends upon their traveling with the seasons - a mobility that isolates them from traditional health care methods. The mean number of workers per family is 3.5 while the mean number of traveling family members is 6.6.[2] Thus, many infants and young children are traveling and subject to the consequences of this mobility.

At least one study[3] has shown that there are few health differences between migrants and others of the same race with similar socio-economic backgrounds; however, their health problems are aggravated by their way of life. Traveling takes them away from familiar surroundings and a single care provider. Each place they stop they must consult a different doctor and even seeing the same doctor within a particular clinic is also difficult. Continuity of care is therefore a major barrier to good

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health care. Transfer of health records also affects continuity of care. It is difficult for migrants to keep track of their health records and take them to the next place of work. For "safe-keeping" records are often left at the home base. Although many migrants bring records with them instream, many doctors prefer to make their own diagnoses and treatment, resulting in possible delays and less efficient and effective treatment.

Living in rural areas and in labor camps that are often isolated from the rest of the rural community further restricts migrants' accessibility to good health care. Crew leaders and growers who own labor camps have been known to restrict visits outside the camps, and visits to camps by outsiders.[4,5] Transportation is a problem frequently encountered by migrants needing to go to a clinic or to buy food stamps. Those who do not own cars must rely on a neighbor, crew leader, or an outreach worker if one is available. Many service facilities are not open evenings or weekends so workers must leave the fields to take advantage of the services. Because migrants are paid on a piece rate or hourly basis, this means losing part of the day's wages.

Language and cultural barriers frequently affect health service delivery also. Most migrants are Spanish-speaking, many with little command of English. If a bilingual staff person is not available, as is frequently the case, the Spanish-speaking migrants frequently can not be served adequately. Staff members often do not have an understanding or sensitivity to different cultural perspectives. The majority of migrants are Mexican Americans and they experience a certain cultural isolation heightened by the language barrier. Folk medicine has frequently been practiced in their culture.[6] Curanderos, or folk healers, are still in used widely. Home remedies and root medicines are often more trusted than standard medical practices.[7,8] Spanish-speaking migrants also differ in their response to health care delivery as practiced in this country. Culturally, they are more sentive to exposing their bodies during a physical examination, especially if the physician is of the opposite sex.[9] Persons providing health care need to be particularly empathetic to such cultural differences. Migrants are also more crisis oriented in their approach to health care - ignoring the problem or seeking non-medical treatments until the problem becomes acute and medical assistance is essential. The medical problem has then advanced to the point where treatment and recovery are more difficult.[10] This is perpetuated by their poor economic situation since time away from work to go to a clinic may cut deeply into the family budget. The midwife or curandero is more readily available in times of need.

A study of migrant use of health care facilities in Florida found that farmworkers tended to use the services of public health nurses and health clinics more than did other county residents.[11] The percentage of the migrant population that visited a doctor, however, was about half of that of other county residents. Also it was found that the presence of a child in the family did not increase the frequency of farmworkers' use of medical facilities.

The availability of health care to migrants represents another major barrier to health service delivery. Rural areas in general suffer from a greater lack of health services than do urban areas.[12] Resources are less developed in these regions. The impact of a particular disease or injury is felt more deeply;[13] thus more school days and work days lost in rural areas than in urban areas. Infant and maternal mortality rates are also much higher, as are work-related injuries. Transportation problems in rural areas are more severe and the lack of doctors in rural areas creates a major difference in availability of health care. There are 138 counties in the U.S. with no federally employed or private physicians, according to the American Medical Association.

Problems with eligibility, such as residency requirements, waiting periods, or verification of income for federal or state programs, further decrease the amount of service available to the migrant farmworker's family. Residency has traditionally been one of the major barriers to health service delivery for migrants while in-stream. Because they cannot prove an intent to reside in a state or county, they have not been eligible for many welfare programs. Despite a Supreme Court ruling against durational residency requirements many states, in violation of this ruling, still attempt to ban migrant assistance on this basis. Fortunately, this requirement has been waived or eliminated in many programs such as food stamps. Another requirement that frequently blocks health service delivery is waiting periods. Migrant families are frequently not in one area long enough to be served. They either must wait because there are not enough service providers to take care of the large influx of migrants into the community or they must wait until the paperwork is completed and eligibility is determined. This can mean weeks of waiting while there may be no food available to the family, unless either an emergency food voucher program or emergency aid from private local organizations is available.

Discrimination is another very real problem facing migrant families as they enter a community and as they attempt to live within it. As outsiders and often as members of a minority group as well, they are not considered part of the community and do not receive the same courtesy as permanent residents with more education and money.[14] While the migrant frequently mistrusts many physicians, preferring root medicine or a midwife, the welfare worker frequently mistrusts the migrant, feeling that "those people will lie to you every chance they get." Chicano migrants are viewed as foreigners; they are the victims of stereotypes built up over the years about Americans of Mexican descent.[15] Their names are different, their color is different; and the prejudice that may result is a serious barrier to obtaining health services. This prejudice not only hinders service delivery, but also may make the farmworkers hesitant to take advantage of services. The second largest ethnic group within the migrant population consists of African Americans; most following the eastern stream and have their home base in Florida. This population suffers from racial prejudice similar to that experienced by the Chicano migrant. While very little literature exists concerning particular problems faced by this population of farmworkers, they too face the same health service barriers. The Black population also has a few distinctive nutritional health problems, such as sickle cell anemia, that must screened for and treated.

The overall health status of all migrant children, therefore, is much poorer than that of the average American. The migrant infant mortality rate is 125% higher than the national rate, as is the maternal mortality rate. The average life expectancy of a migrant farmworker is 49 years as compared to the national average of 70 years. The average

American spends far more on medical care each year than the average migrant spends even though a much higher illness and accident rate is found in this population.[16] "The physical health of migratory farmworkers and their families is in such a state of devastation that it is considered by many to be worse than that of any other group in America."[17]

The majority of the migrant child's serious health problems are due primarily to the child's poor nutritional status. These problems begin even before birth with the nutritional health of the pregnant mother. In a study of the nutritional status of preschool Mexican American migrant children the mean number of pregnancies per mother was 5.7 with 20% having had more than ten pregnancies. The low family income (the mean was $1,885) with such large families means subsistence-level provision of foods and clothing. Of the many families in the study, only twelve were receiving federal assistance and one-third of these mothers had received no prenatal care or nutritional supplements before the birth of their child. Supplemental vitamins were received by only 10% of the infants and one half of the children received no polio or DPT immunizations. Other findings in this study revealed a deficiency in vitamin A that probably had been present since birth due to prenatal malnutrition. However, even greater vitamin A deficiency was seen in those children whose mothers received no nutritional supplements during pregnancy. Low height attainment and a high cholesterol level were also found frequently.[18]

Another study of the nutritional status of migrant children confirmed the existence of low vitamin A levels and general poor nutrition in 40% of the children studied.[19] Ninety percent of the children studied had never been seen by a dentist. In a California survey, all the children studied between the ages of six and twenty-five months were anemic and one-half of those four to eight years old had anemia.[20]

It is clear that malnutrition of migrant children is a major health problem. Low family income, barriers to service delivery, and the transient nature of their lives all contribute to this poor nutritional status. Housing in migrant labor camps rarely allows room for much storage of foods, and lack of refrigeration prevents the family from buying or keeping foods that provide basic nutrients. Insects and other rodents in and around the housing make protection of foods a major problem.[21] The result of this malnutrition can be seen in sores that are not healing properly, low resistence to infection, and extremely poor dental health.

Dental problems are particularly critical among farmworkers because care is sought only in emergencies. Dental caries are common, and the migrant child has little access to dental care. Twenty-five percent of all dental services are extractions;[22] a study in Indiana showed that 76% of all children studied needed dental attention. In Florida, another study revealed that, of those studied, the mean number of filled teeth was less than one, while the mean number of decayed teeth was 6.8.[23]

A recent study of the farmworker situation in the United States showed that there has been virtually no improvement in health conditions over the past few years.[24] This can be partially attributed to the numerous barriers facing a unique minority population and to a lack of nutrition education. Crisis-oriented rather than preventive medicine is practiced due to the nature of the programs that are supposed to serve this population and the cultural orientation of the migrant.

MAJOR FEDERAL LEGISLATION RELATING TO MIGRANT CHILD NUTRITIONAL HEALTH

The unmet health care and nutritional needs of the migrant family are severe and deplorable in a country in which many federal programs exist to meet the needs of low-income families. The requirements for these programs, however, often make them inaccessible to farmworkers. Even so, most health care received by migrant families is provided through these public health programs.[25] The need exists, therefore, to describe these major programs and funding sources to assess their impact, or lack of impact, on migrant health. It will then be possible to determine if the programs are appropriate for this population, to what extent they meet the need, and if not, what changes need to be made.

The Migrant Health Act of 1962(42 U.S.C. 242h)

The Migrant Health Act is the major federal funding source for migrant health care. It provides grants to nonprofit agencies, both public and private, organizations, and institutions to establish family health centers for "domestic agricultural workers and their families . . and conduct special projects to improve health services and conditions."[26] Funding for this program began with $750,000 in 1962. This appropriation rose to $24 million in 1973, 1974 and 1975. The 1976 appropriation was for $25 million. The Bureau of Community Health Services, Migrant Health Division has listed the number of ongoing health projects as 97 and anticipate 92 operating in 1977. The population served and cost per person for 1976 and 1977 are included in the table below.

	1976 Appropriation	1977 Planning Assumption
Workload Data		
Number of projects and Centers on-going..	97	92
Potential eligible population:		
Migrants	714,000	700,000
Seasonal Farmworkers........	2,000,000	2,000,000
Persons served (Total)	(400,000)	(499,000)
Migrants	267,000	334,000
Seasonal farmworkers........	133,000	165,000
Number of encounters............	800,000	998,000
Cost per person served (from Migrant grant funds)..........	$53	$53
Cost per medical encounter......	$23	$25

Source: Bureau of Community Health
Services Migrant Health Division

Health Services Administration
Health Services
Program Analysis

Amendments to the original Act in 1965, 1970, 1973, and 1976 allowed for expanded coverage to include seasonal workers and more services such as hospitalization. Projects can now include "diagnostic and therapeutic care, follow-up, certain dental services, health counseling, preventive care and outreach services."[27] The most recent amendment, recorded in the September 13, 1976 Federal Register, includes new regulations giving the highest priority in funding to projects that are located in areas of highest migrant concentration (6,000 or more migrants and seasonal farmworkers). In addition, priority will be given to grantees in areas where migrants reside for two or more months per year. Community-based organizations are to be given high priority when they include "representatives of the population served . . . and a formal organizational mechanism for involving migrant and seasonal workers and their families in project policy making," according to H.E.W. Lowest priority is now to be given to areas with seasonal workers only.

The Act also specifies that fees and discounts be established for migrant health clinics. Any migrant or seasonal farmworker is eligible for services at a project, and a full discount is provided if the client's annual income falls below Community Services Administration income poverty guideline level. It is safe to assume that most migrant families would qualify for free services. Additional requirements are that a majority of the board governing the project be of the same population as that served, and that provisions be made for quality control in the health clinics.

These changes in regulations answered many of the criticisms levied against the Migrant Health Program. The recent changes, since 1975, resulted from the rewriting of the program as part of the Health Revenue Sharing and Services Act of 1975, Title IV. This legislative change followed a 1973 typhoid epidemic in a migrant camp in Dade County, Florida. Congressional hearings were held in Miami on April 6 and 7, 1973, concerning the "typhoid outbreak and general conditions relating to farmworkers in and around Dade County, Florida." The resulting legislation was vetoed twice by President Ford, but Congress overrode the second veto.

It was estimated in 1974 that 85% of the projects funded were not in compliance with H.E.W. regulations.[28] The majority of these were projects run by state health departments. In most cases, community-based projects, which were providing more comprehensive care, were in compliance with the regulations. The new regulations dealt with this problem by emphasizing community-based projects in high population areas by giving them funding priority. However, these projects may need more technical assistance and help in getting qualified professionals to staff their clinics. The state health department projects that do have high migrant involvement will be hurt by this new emphasis on community projects but should be encouraged to aid community projects, which now must have a majority of migrants on their board who have little or no administrative background.

Areas with a comparatively small migrant population, such as Pennsylvania, will not be helped by such legislation. The Pennsylvania Farm Labor Plan states that Pennsylvania "has no high impact area and therefore should anticipate less federal money for the health program ..." But it is likely that migrant families who are not in high-impact areas have more severe problems getting welfare services since they have even less visibility.

Migrant health projects also have a problem in getting qualified physicians and dentists. This is partly due to the fact that reimbursements are given on a lower scale than for other low-income programs (i.e., Medicare or Medicaid).[29] The number of physicians in rural areas and those willing to work in a migrant clinic are limited. The quality of programs may differ vastly due to the community response and the response of the clinic staff to the migrant population. Services under the Act are supposed to be provided "in a manner calculated to preserve human dignity,"[30] but to insure this the staff must be trained to be culturally sensitive to the needs of the population served. Otherwise, maximum utilization of services will not be achieved.

The Migrant Health Program has been responsible for several innovative programs that have stressed family oriented care, bilingual training, and on-site service. These model programs have included a migrant health insurance plan, coordination with local HMO's to buy insurance packages, and a Migrant Hospitalization Demonstration Program begun in 1974. Basic health care is provided to the farmworkers and their families under the Act, but there is a lack of services in emergency hospitalization, dental and specialty care.[31] The development of local health planning councils over the next few years may provide improved channels for funding migrant-specific programs in rural areas.

Special Supplemental Food Program for Women, Infants and Children (WIC) - P.L. 92-433

Because of the target population that it serves, the WIC program has perhaps the greatest potential for changing the poor nutritional health of the migrant child. The program is run by the Department of Agriculture, Food and Nutrition Division. It was established under the Child Nutrition Act of 1972, but did not actually get underway until 1973 by court order, due to USDA reluctance to implement the program.

The program provides nutritional supplements for pregnant and lactating women, and children under age five who are classified as nutritional risks. This group is the most vulnerable to the effects of malnutrition. Good prenatal nutrition is essential so that infants will not be born underweight and so lactation will not adverseley affect the mother's health. Proper nutrition for infants and young children is important because the most rapid brain growth occurs from three months before birth to six months after birth. In addition, the first three years of life are most critical to bone formation and general growth of the nervous system. Retardation, respiratory disease, or stunting of growth encountered early in life due to malnutrition affects children for the rest of their lives. The damage may be ameliorated but can never be completely corrected.[32] Therefore, the importance of this preventive program for low income families can not be emphasized enough. The participation of migrants in this program should be encouraged because of its great benefits. They have been helped in gaining eligibility for the program because participants are now defined as "members of populations" rather than "residents of areas."

The benefits of the program for the migrant family have been assessed by Dr. William H. Dubrow of the Migrant Health Center at Orange Cove, California.[33] Dr. Dubrow compared clinic visits before and after implementation of the WIC program at the clinic. He found a two-thirds reduction in clinic visits in his 34-child sample. This change was due to a decrease in treatments for respiratory illnesses since the number of visits for accidental injuries remained approximately the same. Dr. Dubrow also assessed the cost-effectiveness of the preventive WIC program versus the cost of regular clinic visits. He found that to keep a child on WIC for 11 months cost $26.00 while it would have cost $92.00 if each child had visited the clinic an additional 3.3 times, as would have been expected before WIC. Benefits to the family are even greater because their purchasing power is increased. Dr. Dubrow concluded that, "It is in the nature of preventive medicine or any program designed to prevent a later occurrence, however, that the benefits may be difficult to measure and may be manifest at points distant in time and place from the point of initial investment. Ultimately the societal benefits are incalculable as they extend imperceptibly into all areas of life activities."

WIC food supplements are provided through issuance of vouchers that can be redeemed for certain foods at designated outlets. Some of the kinds of food provided are: non-fortified infant cereal, fruit juice, non-fortified formula or comparable amounts of whole or evaporated milks, domestic cheeses, eggs, and hot or cold cereal.

Locally, a WIC program may be run by any public or private non-profit group that serves health and welfare needs. This agency will screen for eligibility, distribute the food vouchers and, through a 1975 amendment to the Act, can now provide nutrition education. Local agencies apply for the program to state health departments, which in turn applies to USDA for the funds.

USDA has been taken to court four times for not spending money that Congress appropriated for WIC. In August 1973, USDA was ordered to spend $40 million to implement the program, and most recently, in the 1976 case of Durham vs. Butz, Judge Oliver Gasch of the U.S. District Court ordered that $687.5 million be spent over the next 27 months and that USDA report quarterly on the program's progress. USDA felt that it could only fund 830,000 slots; however, this is less than one third the number of people in need of the program.[34] It is clear that the Department of Agriculture has been negligent in servicing a needy population, and that many have gone unfed without due cause.

However, a recent change in USDA's method of allocating the funds offers some hope. Allocation used to be on a first come first served basis until Congress, in an amendment (P.L. 94-105) to the Child Nutrition Act of 1966, mandated that areas most in need get funding priority. National risks are now considered by the number of live births, low income levels, and low birth weights in an area, as well as to differences between rural and urban populations. This change should help migrants because they usually reside or work in rural areas, they have low incomes, and most migrant mothers and children are nutritional risks.

WIC service delivery poses several problems for the migrant population, however. Migrants must be recertified at each clinic while traveling in-stream. WIC is a community-based program and most outlets are "not prepared to pick up transient participants such as migrants."[35] Migrants may not be able to take advantage of the program unless slots are reserved specifically for them when they enter an area. Another major problem is lack of refrigeration for food received. City residents sometimes have direct delivery service making it possible to keep smaller amounts on hand, but many migrants in rural areas must try to store the food.[36] Again, the need for both bilingual staff and vouchers is important. A study on the WIC delivery system found that 54% of the clinics had a bilingual person on staff but only 6% of the clinics print vouchers in more than one language. Transportation was provided free at 53% of the clinics but only 15% were open evenings and weekend hours. This study also found that some families receiving WIC benefits have incomes over 200% of the poverty level. More needy migrant women and children may be excluded from the program because slots are already filled by families with higher incomes.[37]

If these problems can be solved then WIC will be available to more migrants. A preventive program such as this can save money for both the participating families and other federally subsidized health programs. It has the potential for improving the poor nutritional status of migrant children and thereby helping to protect them from both congenital and environmental diseases.

Food Stamp Act of 1964

The food stamp program was enacted in 1964 and replaced the Food Commodity Distribution Program in most counties nationwide by 1974 and it has since been available in all counties. It is not a program that was designed to serve migrant farmworkers specifically, but rather to improve the nutrition of any low-income families. The purpose is to provide the family with greater food purchasing power by enabling them to obtain a wider variety of foods.

Although the program is run by the Food and Nutrition Service of USDA, it is administered by state and local authorities. States may make their own regulations so long as they comply with the federal guidelines. Thus, rules of eligibility and benefits may vary across states, which would particularly affect the migrant family. Applications must be provided to anyone upon request and, when submitted, must be accepted. There has been a great expansion of the program since it began in the early 1960s. It is now serving approximately 18.5 million Americans although 29.6 to 30.8 million are eligible. Therefore, despite a great deal of expansion of the program since its inception, it still serves only about 60% of the Americans who are eligible. The cost was

$4.7 billion in 1975 and $5.9 billion in 1976. This increase may be due to the entry of many more counties into the program, the transfer of other counties from the food commodity program to food stamps, rising food costs, and the rise in unemployment.[38] More recently, however, there has been a diminished 'demand' for the program in that fewer people are applying for benefits.[39]

There have been many criticisms of the program and calls for legislative reforms. Most criticisms center on eligibility of middle income families and students, the cost of the program, and the question of whether nutrition is actually improved through use of the program. Many of the proposed legislative changes involve shrinking the program and would have adverse effects on migrant farmworkers, because of their unique needs. According to the Migrant Legal Action Program, the "Food Stamp Program is frequently the sole barrier between them and starvation."[40]

As it now stands, a quality control program is run at least once a year by the regional Food and Nutrition Service office to review programs and see that those receiving benefits are in fact eligible.[41] Most migrant farmworkers are eligible to receive food stamps while traveling in-stream. Also, USDA has issued regulations to help deal with the particular problems that migrants have in receiving food stamp benefits. These regulations include:

- Allowing designation of someone other than the head of household to represent them in application or eligibility interviews. This means time off work is not essential.
- A family does not need to have a formal or conventional kitchen facility - most migrant camps would not have met this eligibility criterion.

- A transfer form is available if a family is receiving food stamps in one area and plans to move to another area. The form allows the family to receive the same benefits for 60 days before re-certification is necessary.

- Most recently, and of utmost importance, is the regulation that allows migrants to be certified at the zero purchase level regardless of anticipated income. This resulted from the case of Gutierrez vs. Butz, August 6, 1974.

Despite these regulations many problems still exist for migrants in receiving food stamps. This is due partly to the other regulations that apply to all applicants and partly to the lack of enforcement at the local level of beneficial regulations. A recent survey project by the Compliance and Enforcement Division of the Office of Civil Rights, USDA, through site visits and interviews, assessed the migrant farmworker situation as regards their use of USDA programs, especially the food stamp program.[42] Results showed that there were inconsistencies in the way the program is conducted in various states, indicating a need for increased monitoring of the program. Until the recent change in determining income, the biggest problem for migrants was income projection. Anticipated income was an inaccurate method of determining benefits because their work varies with weather and crop conditions. The food stamp program also requires that cash be paid for the coupons. In some states a two-week supply of coupons must be bought and it can be difficult for the migrant to have this amount of cash on hand. At times, the USDA survey reports, agencies have inadvertently given excessive amounts of coupons to migrant families and then tried to collect the amount in cash to correct the error. When no cash is available, the amount has been deducted from benefits the family may be getting from other federal programs. It is hoped that much of this confusion will be eliminated by the zero purchase level ruling which applies until March 1977.

Other problems migrants have had in computation of family income include eligibility workers incorporating the income earned by children under 18 years of age despite a regulation prohibiting this inclusion. Also, the rental value of often unsanitary substandard camp housing is considered as income. Owning property in the home base has caused problems by also being added as income. However, mortgage payments made out of state will not be counted as expenses. Food stamp office eligibility workers are asked to determine if property owned in home base is also being rented.[43] Thus, out of state income decreases the food stamp allotment but out of state expenses will not help increase food stamp allotment. Emergency grants, even for one-time recipients, are included as income. With all these requirements to check with a family that keeps few records, in-stream income verification becomes a large obstacle to receiving food stamps within a reasonable period of time. The federal regulations require that all applications be processed within 30 days; however, in a recent study of the Food Stamp Program by Congressional staff, it was found that 16% of the cases were not processed within 30 days after initial contact.[44] Ten percent were not processed within 30 days after submission of the application. Many projects do not keep records of when initial contact is made, so it is difficult to determine which of the regulations are being followed. Needless to say, the limit of 30 days can be a very long time when a family has very little or no income and must seek emergency aid.

Income verification has been difficult from another standpoint - causing additional delays in certification. In many cases migrants must obtain an employment statement specifying wages earned. Employers or crew leaders frequently refuse to cooperate in verifying the income of their employees. Crew leaders and employers also "are averse to providing transportation into town for their charges, except on Sunday."[45] Certification offices are rarely open on weekends or evenings. Long waits are often required especially where a large area is served by a very few offices.

Additional barriers to service delivery include:

- Needing separate cooking facilities - some camps have only one large kitchen for all workers
- Rude and discourteous treatment
- Lack of bilingual personnel
- Offfices not using, and explaining the use of, the USDA transfer form 286
- Refusal of receiving offices to honor the transfer form
- Proof of citizenship to screen for illegal aliens when no other group is required to do this
- Camps are closed for not meeting OSHA standards resulting in migrants sleeping in trucks or cars. They then have no "specific home address" and are denied certification.
- The problem of refrigeration and storage surfaces again. Migrants must purchase a two-week supply of food at one time. This restriction forces the users to buy foods that are more easily stored - such as soda pop - rather than nutritionally adequate foods. Few studies have looked at the effect of food stamps on diet and there is little reason to believe that the program significantly improves nutrition.[46]

The availability of this program is very important to the migrant household, yet state or federal policies aiding their participation are not automatically carried out at the county level.[47] Local interpretations of the rules as described above and discrimination against migrants make migrant use of the program extremely difficult.

National School Lunch and Child Nutrition Act, 1975

There are several programs provided under this Act that can affect the nutritional status of the migrant child. These programs are administered by the Child Nutrition Divison of USDA'S Food and Nutrition Service and include the Child Care Food Program, National School Lunch and School Breakfast Program, the Special Milk Program, and the Summer Feeding Program. They were designed to improve the nutrition of children from low income families enrolled in a variety of child care institutions or schools.

The Child Care Food Program (P.L. 94-105) began in 1968 to meet the nutritional needs of children not in schools. Any nonprofit, tax exempt, licensed child care institution receives benefits upon request. This is an "entitled" program based on "performance funding." This means that there is no limit to the number of children that may be served since the institution is reimbursed on the basis of the income of the children served, the number of children served, and the type of meals provided. Unlike an earlier version of the program there is no ceiling on the amount of funds available, nor formula division of the money among the states.

The number of children served by the program has more than doubled since its inception as this chart shows:

CHILD CARE FOOD PROGRAM: HISTORY OF GROWTH

	Number of Institutions	Number of Children	Cost (including nonfood assistance)
FY '72	4,059	215,490	$15,188,841
FY '73	4,396	225,278	18,315,456
FY '74	8,415	377,229	28,225,225
FY '75	9,471	441,046	47,248,000
*FY '76	12,865	463,000	76,720,000

From: Facts About The Child Care Food Program
The Children's Foundation

* Preliminary figures from USDA, Child Nutrition Division

Benefits under the Child Care Food Program include cash and free and reduced price meals to day care centers, family day care homes, nurseries, settlement houses, and recreation centers. Three meals may be provided: breakfast, lunch (the same as dinner) and a supplemental snack.

Children are eligible for free meals if the family income is below 125% of the Income Poverty Guidelines. Reduced price meals are provided if the income is between 125% and 195% of the Income Poverty Guidelines; above 195% the meals must be paid for unless there is a hardship case.

Migrant children should have little difficulty qualifying for and participating in the program so long as they are attending a child care institution of some kind. Unfortunately, the availability of child care for the migrant family is presently very limited, especially for young children who need the nutritional benefits the most.

Several regulations make this a particularly easy program to participate in. Income is determined by self-certification and the program can begin immediately when the child enters the child care institution.

Non-food assistance is also provided for food service or preparation equipment on a 25%, 75% state and federal match. If the area is "especially needy," as defined at the state level, the federal government will pay 100% of this cost. This may be especially helpful for migrant child care centers that are just starting up or have difficulty making ends meet with insufficient funds.

There is some evidence, however, that the program may not be reaching all the children it could. According to Richard Feltner, Assistant Secretary of Agriculture, in 1975, "nearly 700,000 needy children are not participating in the Child Care Food Program."[48]

The School Breakfast Program began as a pilot project in 1966. Formerly, it received less money and priority since participation was given to schools in poor economic areas or which had students who traveled long distances. Reimbursement of 100% of cost was given to schools unable to bear the cost of the program. In the 1975 amendments to the Act the Breakfast Program was made, like the Lunch Program, permanent and available to all schools upon request.

The Children's Foundation, Washington, D.C., completed in May 1976 a statistical analysis of participation in the program.[49] It was found that only 2.5% of the children participating in the school lunch program are also receiving breakfast. In addition, only 14,438 schools are using the program while 86,969 are using the lunch program. Out of eleven million eligible for a free breakfast, only 1.7 million children are reached. The need for more outreach into the communities and encouragement of the schools to request the program is apparent.

The Summer Feeding Program began in 1968 and provides free meals to sponsors which are nonprofit, non-residential, tax exempt institutions. Sponsors are required only to offer the meal service - no other child care activity or educational program is necessary. Again, entitlement funding is used, and meals can be prepared on-site or catered. Areas served by this program must include one-third youths who would be eligible for free or reduced price meals. In this program sponsors must apply at least 30 days before planning to begin the program, although states may shorten this requirement if they so desire. The Summer Feeding Program has been expanded to include vacation periods at any time of the year so long as the recess is at least 15 days in length. The purpose served by this program is to provide hungry children with meals even when school is not in session.

The School Lunch Program is similar to the Child Care Food Program in that it provides free and reduced price meals. Again, once the children are enrolled in a school they can begin to receive meals within five days or as soon as they move into an area. Legal redress is specified if a family is forced to verify their income other than by self-certification. Schools must advertise this program, and in Spanish if necessary. Meals must be served in the same manner as they are served to other children - no separate lines, eating areas, or identification of participants - to prevent discrimination. The basic premise is that children have a right to nutritious and appetizing meals. To help ensure this, funds are provided to hire mothers as aides to assist and teach others to prepare foods that are palatable to ethnic minority groups.

One study of program participation in the state of Washington during the 1972-73 school year[50] found that 65 of the 317 school districts did not fully participate in the National School Lunch Program. Reasons for partial or non-participation varied from lack of facilities to not realizing possible nutritional benefits. This is shown in the chart on the following page depicting some of the results of the study. Low participation of students appears to increase per-pupil cost.

Another study in Washington state in 1975 analyzed some of the problems and causes of low participation.[51] Results showed that some parents felt a sack lunch was cheaper, the food served was not palatable to the children, and in one district 34% of the parents had no knowledge of the program. In addition, it was found that 12% of the children were aware of which classmates received free or reduced price lunches.

The Special Milk Program was established under the 1966 Child Nutrition Act. Like the other programs under the Act it is provided to nonprofit institutions, not directly to the families, on request. Currently a 6¢ reimbursement is given for ½ pint fluid milk. There is no limitation to the amount of milk provided to a child. The only restriction is that milk cannot be provided if the child is receiving the supplemental snack in the Child Care Food Program or free lunches. In these cases the Milk Program is usually not used since the reimbursement rate is better in the other programs. In fiscal year 1975, according to USDA, 88,000 institutions participated in the program and 2.1 billion half pints of milk were served last year.

Alternative lunches and major reasons for districts/ not participating in the National School Lunch Program.

Type of district	No of districts interviewed	Primary reason for not participating in the NSLP	% of students eating sack lunches	Alternative food service available
Never Participated	7			
Concentrated	3	No nutritional needs - 2 districts districts Lack of facilities	25	PTA--once a week - 1 district None - 2 districts
Rural	4	No nutritional needs - 3 districts Lack of facilities - 1 district	95	PTA--twice a month - 1 district None - 3 districts
Previously participated	10	Financial	85	Hot sandwiches - 1 district (all grades) Vending machines - 2 districts (Jr. & Sr. Hi only) None - 7 districts
Partially participating	13	Student food pref. - 9 districts Lack of space & cost of operation - 2 districts Lack of facilities - 1 district Lack of knowledge of type A flexibility and regulations - 1 district	50	A-la-carte service - 7 districts Vending machines - 6 districts

While these programs are comparatively easier for the migrant child to participate in, and simpler for the family to apply for, children must first be enrolled in a school or child care institution. In addition, the school must be participating in the program. What may then prevent them from receiving the benefits of the programs may be transportation, lack of available slots in child care programs, discrimination, or the need for the children to work with the family in the fields. These programs and their use by migrant children were evaluated by USDA and no problems became evident.[52] Very few investigations or evaluations have been made, however, so few conclusions can be drawn concerning the effectiveness of these programs. The nutritional benefits of the programs also have not been thoroughly investigated.

Social Security Act

The Social Security Act provides what are typically referred to as "welfare" services. Under various titles of the Act are included: Medicaid, Aid to Families with Dependent Children, Aid to the Permanently and Totally Disabled, Aid to the Blind, and Old Age Assistance. These programs, however, are rarely of much use to migrants because of the eligibility requirements. One such requirement used to be residency, but a 1969 Supreme Court ruling declared it unconstitutional to require a person to live in a particular state for 12 months or longer.[53] However, most states require a family to prove an intent to reside in the state before they can be eligible.[54] AFDC requires that the family not have a father present in the home, or a few states allow that he be unemployed in order to receive assistance. Most migrating families include a father and he is frequently employed, thereby eliminating

AFDC eligibility.[55] AFDC does, however, include provisions for migrant workers with needy families to receive emergency assistance for a period not in excess of 30 days in any 12 month period. Regarding the other welfare programs, few migrants are aged (over 65) since the average life expectancy is 49 years, and few migrants are blind or disabled. Of those who are handicapped few are not aware of, or not enrolled, as shown in the chart on the following page.

Title XIX - Medicaid

Medicaid provides cash and medical assistance in a tax funded state - federal program. The program was enacted in 1965 to improve the health care of low-income families, allowing health care to be provided to children 0-21 years of age. Eligibility for Medicaid, however, is linked to the other programs in the Social Security Act. Benefits are only given to individuals already receiving AFDC or some other program of categorical assistance. However, a portion of the funds allocated may be used for the "medically indigent" at state option. Only 32 states in 1975 had a medically indigent program. Several sources attest to the fact that few migrants, therefore, qualify for Medicaid assistance.[56]

Early, Periodic, Screening, Diagnosis, and Treatment (EPSDT)

In 1967 (P.L. 90-248), EPSDT was added as a requirement to the Title XIX, Medicaid Program. It is a grant-in-aid program in which the states are reimbursed for treating eligible children. Beginning July 1, 1969, screening and treatment of medicaid eligible children was to begin. The state agency was to draw upon its resources to implement

AWARENESS OF, APPLICATION FOR, AND RECEIPT OF PUBLIC SERVICES BY FARMWORKERS

Kind of Service	Percent aware of services	% of those aware who applied for services	% of applicants who received services
Social Security	76	34	38
Unemployment Compensation	63	42	9
Aid to the Blind, or aid to the disabled, including ATD	53	13	*
Aid to Families with Dependent Children: AFDC, ADC, AFDC-U	43	23	*
Programs for pensions or disability benefits paid by employers or unions	39	17	
State programs for sickness and temporary disability benefits	32	10	

*Base too small to estimate

Source: Interstate Research Associates, Handicapped Migrant Farm Workers (Contracted by the U.S. Department of Health, Education and Welfare.) Washington, D.C., December, 1974, pgs. 61-62.

this program, but regulations were not issued until late in 1971, and full coverage regulations were not issued until 1973.

Regulations required screening to cover a health and developmental history, assessment of physical growth, developmental assessment, inspection for obvious physical defects including ear, nose, mouth, throat, teeth and gums. Tests for cardiac abnormalities, diabetes and other diseases are also included. Follow-up treatment or further study must be provided if necessary.

A 1972 study, including data from 44 states, found that a great number of children (almost 2,500,000) were reached by Medicaid in 1974 at a cost of approximately $300 per child per year.[57] This would seem to be a great amount; however, two states reported having no Title XIX program at all, and one state reported having no Medicaid program for children. No breakdown in the number of migrant children served is available.

A recent report to Congress by the Subcommittee on Oversight and Investigation assessed the EPSDT program.[58] It was found that in 1975 approximately 10.9 million children, out of an eligible 12.9 million, had not been screened. The Subcommittee stated that of these 10.9 million children approximately 2,855,000 would have perceptual defects, retardation, or iron deficiency anemia. The report also discussed the fact that in 1973 the Center for Disease Control reported that one out of every three preschoolers are not receiving full immunizations. It is clear that the program is not being implemented and monitored effectively. The great need for the program is also emphasized by the report's findings.

EPSDT, like the WIC program, is a preventive program and can have great impact on the health of children now and in the future. The

Subcommittee found that is has "extraordinary potential in cost benefit terms ... It was estimated that a complete preventive child health care program to the time a child is 16 years old (approximately $1,000) would be comparable to a two week confinement at a hospital at today's prices."

A great weakness in the EPSDT program appears to be that there is too much emphasis on screening, while treatment and follow-up are neglected. This poses more significant problems for the eligible migrant children because no system is available to trace the screened children through to treatment. When a migrant child enters an area for a short period of time, treatment and cure of any problems can not necessarily be completed before the family leaves the area. Recommendations were made by the Oversight and Investigations Subcommittee to investigate expanding eligibility to cover more children. Hopefully, more migrant children could become eligible and Title XIX could be made an additional funding source for clinics, day care centers, or health departments to use in providing better health care for needy migrant children.

Another funding source in the Social Security Act through the Bureau of Community Health Services that may affect health and nutrition and its effects on children is Title V, Maternal and Child Health and Crippled Children's Services. This provides grants to states for dental health, special projects, maternity and infant care, and intensive care of infants. No data is available concerning the number of migrants served.

Title XX, Grants to States for Services, can include transportation, preparation and delivery of meals, nutritional counseling and health support services. This is more fully described in Chapter IV, Day Care.

Community Food and Nutrition Program (Emergency Food and Medical Services)

The Community Food and Nutrition Program was created in 1974. The name of the program was then changed from Emergency Food and Medical Services Program, and the medical activities were transferred to H.E.W. The program was orginally begun under Title II of the Economic Opportunity Act of 1964, but since the termination of OEO the program has been operated by the Community Services Administration (CSA).

The purpose of the program is to "fill in the gaps" of other federal feeding programs by analyzing and overcoming barriers to participation at the community level. A 1967 amendment stated that the program should "provide such basic foodstuffs and medical services as may be necessary to counteract conditions of starvation or malnutrition among the poor." In addition, an emergency is defined as any case of hunger, malnutrition or starvation, not just as assistance on a temporary basis.

Migrant and seasonal farmworkers, along with Native Americans, became a target group in 1975 when Congress mandated that 15% of the Community Food and Nutrition funds be earmarked for projects serving these populations. A recent report to the Comptroller General of the United States on the operation of this program, however, found that some projects were being misclassified and actually not serving the target groups.[59] In 1974, CSA reported 19% of the funds had gone to these populations but in fact, the report states, due to the misclassifications they probably did not reach the required 15% level. No guidance had been provided to insure proper use of the funds. The 1976 Pennsylvania Farm Labor Plan also reports past misuse of funds from this program. In

1975, however, a new system for funding migrant and seasonal farmworkers was begun. Funds are now placed with migrant agency grantees which can more easily act as conduits to discover problems and provide funds to agencies, such as local Community Action Programs (CAPs), in an area of crisis.[60] The conduit keeps track of the funds and reports to the CSA office.

Several recommendations were made in the Comptroller General's report that have been incorporated into CSA's new FY 1976 guidelines for the Community Food and Nutrition Program. These include special funding emphasis on migrants, seasonal farmworkers, and Indians; better monitoring of the program rather than relying solely on agency self-assessment; and keeping better data on the populations served.

Despite cases of misuse of funds the program has flexibility and provides a necessary service. Funds can be used to aid a family in receiving food stamps or to provide money until the application is processed. Transportation and consumer/nutrition education may also be provided. This service is, therefore, one that migrants easily qualify for and can be useful to them. In recent years, however, a zero budget request has been submitted by the administration in an attempt to drop the program.[61] One reason given for this is that the program duplicates existing feeding programs, but no duplication of services was found in the report on the program's operation. It is only due to the continued support of Congress that money, $26.2 million in 1976, is appropriated to continue the program. The end of the program would discontinue a needed source of federal funds for the nutritional health of the migrant family and could only be seen as a detriment to their welfare.

SPECIAL PROGRAMS

A unique model program for migrant families is an "insurance type" program originally funded by the Bureau of Community Health Services for $378,000 and for $700,000 the second year the project operated.[62] The project is the East Coast Migrant Entitlement Project run by the West Palm Beach Health Department and administered by the Florida Department of Health and Rehabilitative Services. The migrant families who wish to participate are informed of the project in their home base state of Florida through the outreach work of the East Coast Migrant Project and the Red Cross. Enrollment and client education concerning how to use the medical care effectively took place in Florida and up stream along the east coast into New York State. There is no premium and no risk, with little cost to the family involved in the use of the project. The families are provided with Blue Cross/Blue Shield cards that can be used for public or private medical services. Blue Cross/Blue Shield is then reimbursed from the project funds.

From the beginning, January 1975, the program has been well utilized and while it was intended to serve only the east coast stream some migrants have used the cards in other areas where they have migrated. Approximately 2,000 migrants have taken advantage of the program and almost all have received care under this coverage. As reported by Eugene Boneski, project director, the number of children served were:

ages	1 - 4:	232
	5 - 9:	234
	10 - 14:	273
	15 - 19:	277

The population served is 1,554 Black, 271 are Mexican American, 217 are Puerto Rican, and 30 were classified as "other."

While the cost effectiveness is yet to be determined, the program is reported to work quite well. Only 36 refusals of service were encountered and a few migrants have forgotten to carry their cards when needing medical services. One shortcoming in the program is the limitations on the services provided since prescription drugs, eyeglasses, and hearing aids are not covered at all, and dental care is limited.[63]

The program seems a worthwhile and effective one which can be used anywhere as long as proper outreach, client education, and information concerning the program's existence is dispersed to service providers.

Another program that is helping to solve the problem of lack of continuity of health care for migrants is the National Migrant Referral Project, Inc. in Austin, Texas. This project, an old OEO program, is funded for $150,000 by the Bureau of Migrant Health, Public Health Service. It consists of two major "tools" to facilitate continuity of health care.[64] The first is a directory (National Migrant Health Service Directory) which lists medical facilities nationwide that are located in home base and in-stream areas. Included are: Migrant health clinics funded by H.E.W. and state and local public health facilities in home base or high impact areas. In 1975, the Indian and Migrant Programs Division of H.E.W. provided funds for the participation of migrant head start centers. This funding was not continued so day care centers participate only on a voluntary basis and their participation is not accorded priority in the Referral Project.

The second tool provided by the project is a referral form in two versions, a general form and a pediatric form especially for young children which includes more detailed information of children's immunization history. These forms are filled out by the doctors or health care workers in the medical facilities if the patient requires follow through on the care provided. Copies of the completed forms are sent to the facility closest to the patients' stated destination. The name and address of that facility can be found in the directory. All vital statistics such as sex, age, parent's names, ethnicity, etc. are included on the form along with the health problems. A code for the particular disease entities (e.g. International Classification of Diseases) is recommended to ensure patient confidentiality and copies of the forms are kept by the referral initiator, the patient, NMRP in Austin, and the receiving agency. Forms are explained to the patients in English or Spanish, who are then told to take their copies to the next health agency they contact. The receiving agency then is supposed to complete a section of the form detailing the outcome of the referral, whether services were provided or not. They keep a copy, send copies to NMRP in Austin who then sends a copy back to the original health facility. If the migrant does not contact the health facility as advised when moving to a different area, the outreach workers there, if available, can attempt to find the family.

According to NMRP 4,452 initiated referrals were processed FY 1975 and 57.4 percent were completed.[65] Two-thirds of the referrals in the first half of 1975 received the services requested completely (47.7%), or partially (19.1%). The major reason for the others not receiving the service was that the patients could not be located. NMRP also reports that the largest single age group of referred patients was infants under one year of age, and more than twice as many females were referred as males. An overwhelming majority of those served are Mexican Americans and the major services requested for this group were immunizations, prenatal services, diabetes, hypertension, and ENT/ vision. The outcome of the referrals and success rates by the age of the patient are shown in table on the following page.

This system is relatively easy to use and takes a major step toward continuity of health care. It does, however, rely heavily on the patients knowing their destination and carrying their records with them. Many clinics do not have an outreach program and the clinic must then wait for the patient to come for medical assistance. Depending upon the severity of the condition this contact may be extremely important for the health of a child or parent. A similar system, also funded by H.E.W. is the ESEA Title I, Migrant Education program which keeps computerized health records on all children enrolled in the Title I Migrant program. This system will be described in more detail in the chapter on education. Coordination between the Title I Migrant Student Record Transfer System and the National Migrant Referral Project could be very valuable in preventing duplication of services and in locating children who have moved to a different area and have not been taken to a clinic. According to Tomasa Nilo, assistant director of NMRP, however, this coordination does not exist due to difficulties encountered in sharing the information. Another system for the east coast and mid-continent streams called the Migrant Health Service Referral System is

Referral Outcomes and Referral Success Rates by Age of Patient
NMRP, Migrant Season, 1975

Age	Total Number	Total Percent	Complete Service Number	Complete Service Percent	Partial Service Number	Partial Service Percent	No Service Number	No Service Percent	Unknown Number	Unknown Percent	Success Rate	Revised Success Rate
Less than 1	149	100.0	77	51.7	24	16.1	38	25.5	10	6.7	67.8	72.7
1-4	366	100.0	147	4012	67	18.3	121	33.1	31	8.5	58.5	63.9
5-9	148	100.0	72	48.6	33	22.3	30	20.3	13	8.8	70.9	77.8
10-14	119	100.0	50	42.0	32	26.9	29	24.4	8	6.7	68.9	73.9
15-19	213	100.0	102	47.9	36	16.9	59	27.7	16	7.5	64.8	70.1
20-24	291	100.0	115	39.5	52	17.9	72	24.7	13	4.5	57.4	60.1
25-29	177	100.0	85	48.0	36	20.3	48	27.2	8	4.5	68.3	71.6
30-34	116	100.0	62	53.4	14	12.1	33	28.4	7	6.0	65.5	69.7
35-39	142	100.0	61	43.0	31	21.8	41	28.9	9	6.3	64.8	69.2
40-44	149	100.0	65	43.6	27	18.1	47	31.5	10	6.7	61.7	66.2
45-49	207	100.0	95	45.9	38	18.4	63	30.4	11	5.3	64.3	67.9
50-54	153	100.0	66	43.2	29	19.0	46	30.1	12	7.8	62.2	67.4
55-59	108	100.0	41	38.0	18	16.7	41	38.0	8	7.4	54.7	59.0
60-64	65	100.0	27	41.5	18	27.7	19	29.2	1	1.5	69.2	70.3
65 and Over	31	100.0	18	58.1	5	16.1	7	22.6	1	3.2	74.2	76.7

From: Computer Analysis of Referral Process
Migrant season 1975-76
by Dr. Sam Shulman, Houston, Texas

also in existence. Coordination of these systems would provide comprehensive records of treatment and avoid duplication of services. The more comprehensive knowledge available about a child's health, the better will be the health care.

SERVICE DELIVERY AT STATE AND LOCAL LEVELS

Migrant farmworkers and their families are almost totally dependent on federal funding for their nutritional health. They can not afford private services, in almost all cases, since their average income is $3,900.[66] Most migrants have no form of health insurance or enough cash on hand to utilize private hospital facilities or local doctors and dentists. Even if they did, the hours are usually inconvenient, transportation is a problem and there is a lack of doctors available in rural areas. Discrimination has also been a problem in allowing migrant use of private facilities. Essentially they are closed to them. Many cases have been cited where migrants and their sick children have been sent away from hospitals for lack of cash, insurance, or sheer discrimination on the part of the workers.[67] As an example of the insensitivity encountered by the migrant, Gordon Harper, M.D., in Congressional testimony recounted:

> "Babies die all the time" said one grower, when asked about a notorious case of nine-month-old who died last year of diarrhea and dehydration, after being refused admission to a hospital in Southwest Michigan; "why should they get so excited when one dies here?"[68]

Few services are provided solely through state funds. The states frequently match federal funds as described in the legislation above, but otherwise have few programs specifically for the migrant family. State agencies vary in the extent to which they are concerned about their public programs reaching the migrant worker.[69] Some are very passive and barely acknowledge the existence of migrants in their state, while others may fund outreach workers and place a priority on reaching the families in isolated camps. Most migrant families are "income eligible" for Title XX services, while a few states have special group eligibility for migrants wishing to receive Title XX benefits. This does not mean, however, that outreach is provided so that the services are utilized.

A few states, Indiana and Pennsylvania for example, have state supported migrant health nurses in some counties. These nurses visit local schools and labor camps. Colorado has experimented with a health care system using physicians on a rural military base.[70]

The services provided at the county health department are purportedly available to the migrant family as well as anyone else in the community. However, unless bilingual staff has been provided many migrants can find no assistance at this outlet. Washington State has a limited state-funded Medical Only program, apart from medicaid, for which migrants would be income eligible. Unfortunately migrants are hardly a service priority when it comes to state/county supported services. Priority is given to county "residents" who pay taxes in the state. Migrants are not accepted as their responsibility and are encouraged to use services for farmworkers only.

One example of a state funded program for the migrant family is seen in the cooperative extension services of Wayne County, New York and in Florida. They cooperate in a year-round Nutrition Education Program for migrant families and are funded by the New York State Bureau of Migrant Education. Nutrition aides work on a one-to-one basis with the families in their homes to improve nutrition. Consumer education, food storage and sanitation, and information on available resources are also provided.

The only other sources of health assistance for the migrant family are through private, voluntary organizations or through the farmworker organization. There are Migrant Ministries and State Councils of Churches in many states that act either as grantees for federal funds, or volunteer to gather emergency foods or provide transportation to medical facilities. The farmworker organizations are primarily funded by the Department of Labor, Comprehensive Employment and Training Act, Title III Section 303, a manpower training program for farmworkers. Under CETA 303 is a health component that allows expenditures of an average of $250 per family with $500 maximum per family. These funds, however, are primarily used for manpower trainees and their families for check ups and medical emergencies. A smaller amount of funding is available to assist those wishing to remain in agricultural labor. The farmworker organization grantees are relied upon by the migrant family to a great extent. As migrant advocacy groups, they can help eliminate many of the barriers to health care delivery by providing emergency assistance, aid in filling out forms for services, translate instructions or problems in Spanish or English, provide outreach, and help to foster better community relations.

A variety of federal programs are bearing primary responsibility for the health and nutritional care of the migrant child. These programs are occasionally supplemented by state programs and matched by state funds. It has been documented that these programs are not reaching enough of the eligible and needy population due to a variety of service barriers. These barriers are found in the federal and state program regulations, their various interpretations by eligibility workers, poor community response and discrimination, and cultural insensitivity. Without efforts to eliminate these problems the disastrous and unchanging nutritional status of the migrant child will not be improved.

The nutritional health of a child, however, can not be looked at in isolation. The child's family housing and total environment affect his or her health and overall well-being. The role of the environment in the health of the migrant child will be discussed in the next chapter.

CHAPTER II

ENVIRONMENTAL HEALTH AND MIGRANT CHILD DEVELOPMENT

> "No group of people I have worked with -- in the South, in Appalachia, and in our northern ghettoes -- tries harder to work, indeed travels all over the country working, working from sunrise to sunset, seven days a week when the crops are there to be harvested.
>
> There is something ironic and special about that too: in exchange for the desire to work, for the terribly hard work of bending and stooping to harvest our food, these workers are kept apart like no others, denied rights and privileges no others are denied, denied even halfway decent wages, asked to live homeless and vagabond lives, lives of virtual peonage,...
>
> I do not believe the human body and mind were made to sustain the stresses migrants must face -- worse stresses, I must say, than any I have seen anywhere in the world, and utterly unrecognized by most of us. Nor do I believe that a rich and powerful nation like ours, in the second half of the twentieth century, ought tolerate what was an outrage even centuries ago: child labor, forms of peonage; large scale migrancy that resembles the social and political statelessness that European and Asian refugees have known; and finally be it emphasized, for people who seek work and do the hardest possible work, a kind of primitive living that has to be seen, I fear, to be understood for what it does to men, women and most especially children."

Testimony of Dr. Robert Coles, in Hearings Before the Senate Subcommittee on Migratory Labor, 91st Congress, 1st Session, "The Migrant Subculture," July 28, 1969, Part 2, p. 335.

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p. 50 photo

The lifestyle and environment of the migrant child are unlike those of any other child. Similarities certainly exist with other low income groups such as Appalachians, or sharecroppers, but the constant traveling and adaptation to new and different environments is unique to the migrant. The migrant child has no community and few if any possessions.[1] A few pieces of clothing are passed on from older siblings, and toys or playthings are virtually unheard of in the home. The only continuity in their lives is travel, hunger, and crops. The crops become a frame of reference for the migrants. "The baby was born in the tomatoes of Ohio. The truck tires were new in the spinach of Texas. The older son broke his arm in the sugar beets of Wyoming... These were the crops in which they labored at the time."[2]

Few migrant children are born in hospitals or even with the help of midwives or para-professionals. From birth the children enter a wandering unstable environment but are allowed to explore their surroundings as soon as they can crawl. As described by Dr. Robert Coles in his book, Uprooted Children, the migrant child "does not find out that his feet get covered with socks, his body with diapers..... He does not find out there is music in the air or wake up to find bears or bunnies at hand to touch and fondle. In sum, he does not get a sense of his space, his things or a rhythm that is his." A sense of identity and a good self-concept are difficult, if not impossible, to foster in this kind of environment.

Migrant infants are usually not lacking in the external stimulation that is so important in these early months. Because they are allowed to roam they encounter many objects, and experience close human contact. At first the infants sleep with their parents and then usually with older brothers and sisters.[3] As the infants become toddlers, more active and curious about their effects on the environment, however, the degree to which they encounter harmful agents increases. Healthy exploratory behavior can not always be allowed. As in many low-income homes, migrant children are limited in their large muscle activities by a lack of physical space in the home.[4] In addition, migrant labor camps rarely provide safe outdoor space for a child to play. The protection of migrant toddlers is therefore very difficult. Broken glass, generally unsanitary surroundings -- such as dirt floors rodents, and lead paint chips are but a few of the hazards associated with poor housing conditions.

Babies are breast fed as long as possible for economic reasons, and close human contact is fostered between mother and child. When they must work to help with the family income, mothers often take their infants to the fields. Day care centers are not usually available for all ages and at all the necessary times for those desiring them, and some mothers prefer to know where their children are and have them near at hand.[5] The infants, then, are left in the cars, alone at the edge of the fields, or in the care of other young siblings. The dangers that can be found in the fields are numerous and include farm machinery, pesticides, and irrigation ditches. Cases have been reported of infants suffocating in hot cars while the parents and siblings worked nearby.[6]

The migrant lifestyle and these conditions under which the family must live directly affect the child's social development and behaviors in a variety of ways. For example, "toilet training" is a slow and more casual learning process.[7] The conditions of the outhouses and their distance from the cabins make it especially difficult. Migrant children rarely get to see a real bathroom unless it is in a day care center. A piece of cloth is often used while they are inside the house and children occassionally see their parents use an outhouse or the fields. They are taught to respect the house, or cabin, and the car but waste may sometimes be disposed of near the house thereby increasing the chances for spreading of diseases, diarrhea, and parasites.

FAMILY STRUCTURE

Because of the poor living conditions and the constant change in people and places in their lives, it is easy to see why the family unit plays such an important role in the migrant child's development. Except in the eastern stream, which has a large percentage of single Black males with no families, migrants usually travel in family groups and work together throughout the season. The continuity and closeness of the family unit potentially provide security for migrant children. Siblings are often very attached to each other and to their parents so that in some cases parents are reluctant to separate the children from each other in different schools or child care centers.[8] In other cases, problems of separation from the parents are not often observed; apparently change is accepted as a way of life.[9] The structure of the migrant family is composed of strong extended family ties. This is true of Chicanos, Indians, rural Blacks and southern Whites, all of whom make up portions of the migrant stream.[10] The extended family structure exists as part of their folk culture, to protect family members from outside interference, and for economic reasons to increase family income and care for young or ill members. The extended family aids in preserving the heritage which provides migrants with an identity and helps to protect them since they are isolated from the rest of the community, the growers, and the federal government.[11] Thus, the family becomes an important part of migrant childrens' lives and as they grow older many are eager to help increase the family income by working and also must begin taking care of their younger siblings.

There is some literature which suggests that the extended family tradition is becoming less influential in Spanish-speaking homes.[12] This trend, however, is largely due to a move away from rural areas into urban areas where Chicanos have become more acculturated and some migrants have settled out. In the rural areas, traditions and older customs are perpetuated to a much greater extent.

The sex roles that are reinforced within the family structure affect migrant childrens' development and their response to child welfare services. These sex roles vary among migrant families with the same cultural background, and differ between the various cultures comprising the migrant stream. Sex roles within the Chicano culture seem to be more clearly defined than in other cultures.[13] While the research in this area is not extensive and has some methodological problems, "ideal role models" seem to exist for the Mexican American family, although they may not be adhered to rigidly. Traditionally, the Chicano male is the dominant and controlling personality in the family while the female is described as more passive, vulnerable and is protected more than the young boys. The eldest brother usually has more authority and cares for the family when the father is absent.

Settled-out migrants become acculturated and assimilated more easily, but even within the isolated rural migrant stream things are changing albeit slowly, for the female Mexican American. One young migrant woman says, "It is hard today for a Chicano woman. It is hard to be a wife in the old way and still do the things that people in the training programs suggest... It is indeed hard today to be a Chicano migrant worker who sees the old way of life changing but who still wonders how he fits into the new and what all of this will really mean to the culture of his people."[14]

The rural Black family structure shares several features with the rural Chicano family structure. It too, relies heavily on the extended family and close family friends. Sometimes children may be adopted into other families or raised by relatives. However, many different family patterns can be seen in rural Black communities. It is sometimes claimed that Black families are matriarchal with the woman in the dominant role and the father often absent from the home. However, the majority of Black families include both a husband and a wife.[15] The performance of house-hold tasks may be done by either the man or woman. The rural Black woman has always worked both inside and outside the home because of economic necessity. Also, Black women have always been associated with agriculture, which stems from the tribal culture of various African groups. The woman's domain was the home and the farm while the man's was in hunting and tending cattle. Throughout the period of slavery in this country also, Black women always worked in the fields.[16]

Chicanos and Blacks make up the vast majority of the migrant population; however, the rural family seems to have a common structure regardless of race. Whites and Native Americans in rural areas also have an extended family structure and all family members work. Thus, the rural family is poor but not lacking in support from family, friends, and racial cohesion. Migrant children learn that they are an important and loved part of a large family and are expected to contribute to the family income. While some migrant parents may want their children to get an education, earn enough money not to need welfare or go hungry, the migrant lifestyle and the poor provision of services to this population hinders this accomplishment. Child labor thus becomes a part of the migrant life.

CHILD LABOR

The migrant child has responsibilities much earlier in life than most children. These responsibilities involve either caring for younger siblings or working in the fields. As preschoolers they spend much time just sleeping or playing at the edge of the field until they are old enough to "pick." Many children begin to do some work in the fields by age four, and by age ten are expected to carry their own weight and usually finish any school in order to work full time by age twelve.[17]

The problem of child labor has been eliminated in all occupations but agriculture. Farmworkers have historically been exempt from much of the federal protection provided to other workers since child labor provisions are not so stringent for agricultural as for nonagricultural workers.[18] As reported by the American Friends Service Committee in a report entitled, "Child Labor in Agriculture --- Summer 1970," one-fourth of the farm wage workers in the United States are under 16 years of age. The report also noted that "except for a change in locale ... the child labor scene in 1970 is reminiscent of the sweatshop scene in

1938, if you look at that scene with an adult mind, through a child's eyes."[19] It has been estimated that approximately 800,000 children work in agriculture.[20]

It is clear that children are being exploited, but why and how does this situation continue to exist? One reason, as described in detail by Ronald B. Taylor in his book Sweatshops in the Sun is the myth that "work on the farm is the essence of American virtue."[21] Many people believe hard work gives children a sense of values and responsibilities. What better place to learn these important values than in the wide open spaces of a farm? However, no evidence exists showing that children deprived of such work over the past 35 years failed to develop these values. If it were true, then why should not all children be required to do farm work as part of their education?[22] In addition, the "idyllic farm life" is actually an extremely dangerous environment for a child laborer. Agriculture has the third highest fatality rate per 100,000 workers.[23] It must be made clear that, when referring to child labor, the issue is not working on the family garden, helping with chores on the family farm, or earning pocket money. What is in question is long days stooping and picking, carrying heavy sacks and being exposed to hazards.

The primary reason for migrant child labor is economic necessity of the migrant family. Many growers who have supported the use of child labor claim that without it the crops could not be harvested and therefore, their economic welfare is also at stake. However, it was shown in 1972 in the strawberry fields of Louisiana that no part of the harvest was lost even though 300 children were taken out of the fields.[24] Local people were then recruited and wages were increased. The small volume of productivity does not make child labor a significant factor in farming.[25]

Allowing child labor takes jobs away from adults and depresses adult wages. For the migrant family, however, child labor has remained important since even the small amount of extra money it provides for the individual family helps to put food on the table. Agricultural workers continue to receive a lower wage than that guaranteed to workers in other occupations. Several state laws exempt farmworkers completely from minimum wage standards. As a result, child labor will continue to be an integral part of the migrant farmworker lifestyle.

Migrant child workers have fallen ill or died from hazards such as pesticide poisoning in the fields. One case related by Taylor in his book on child labor described the death of a nine-year old boy in 1971 that resulted from an airplane spraying the crops while migrants were working.[26] This is but one of many cases of young children being exposed to pesticides in the air, in empty cans where residue remains, or at home on the hands and clothing of other members of the family. Symptoms of pesticide poisoning can often be mistaken for other illnesses, making documentation of actual cases difficult. Symptoms resulting from exposure to pesticides or insecticides include: headache, giddiness, blurred vision, nausea, and diarrhea.[27] Prevention of pesticide exposure requires simple labeling of containers so that relatively uneducated persons can understand the necessary precautions, such as proper disposal of containers, watching for wind drift while spraying fields, and knowing the safe re-entry time for the return of workers to the fields. Adequate policing of these activities must also exist to protect all workers, not just children who are more vulnerable to the ill effects of pesticides.

Farm machinery is another major hazard in the fields. Young children have been seriously injured and killed driving and working near tractors and other farm machinery.

MAJOR FEDERAL LEGISLATION RELATING TO MIGRANT LABOR AND ENVIRONMENTAL CONDITIONS

Farmworkers are not receiving equal benefits and protection under federal and state laws. Legislation affecting child labor, farmworker rights, and agricultural working conditions is discussed below.

Fair Labor Standards Act (FLSA)

This federal legislation was first enacted in 1938. It has been gradually amended since then to raise the minimum wage and broaden coverage. Only in 1966 did farmworkers receive coverage on a limited basis. The Act is administered by the Secretary of Labor through the Administrator of the Wage and Hour Division. It sets minimum wage, maximum hours, overtime pay, equal pay, and child labor standards.

In 1966 farmworkers received minimum wage coverage, although this was, and still is, lower than other occupations covered by the Act. The most recent amendment was in 1974 and provided increases in the minimum wage for agricultural workers and changes in child labor provisions. However, the Act also specifies that employers must use more than 500 man-days of farm labor in any quarter of the preceding year in order to be covered by the Act. It also excludes hand harvesters who do piece work for less than 13 weeks. Time-and-one-half overtime pay provisions do not apply in agriculture. It was noted in the "Report of the Department of Labor Task Force" on problems facing farmworkers in 1973, that only 2% of the 1.4 million farms using hired farmworkers were eligible under the 500 man-day provision. This makes only about 35% of the farmworker population eligible for coverage.

The following table shows the minimum wage standards of the FLSA:

Effective Date	Basic Rate	Farmworker Rate	Farmworker annual income from 50 40-hour weeks
May 1, 1974	$2.00/hour	$1.60/hour	$3,200
Jan. 1, 1975	$2.00/hour	$1.80/hour	$3,600
Jan. 1, 1976	$2.30/hour	$2.00/hour	$4,000
Jan. 1, 1977	$2.30/hour	$2.20/hour	$4,400
Jan. 1, 1978	$2.30/hour	$2.30/hour	$4,600

- from Pennsylvania Farm Labor Plan, 1976

State minimum wage provisions covered farmworkers in 15 states as of 1972. Only 9 out of 47 states specifically cover farmworkers through their wage payment and collection law which ensures that employees regularly receive their pay in full and without delay.

The Fair Labor Standards Act provides some coverage for child labor but is less restrictive for agriculture. In industry, children under 16 years of age are not permitted to work. However, children may work in agriculture if they are:

1) 14 years of age or older
2) 12 or 13 years old, and employed with parental consent, or a person standing in place of the parent, or employed on the same farm as the parent, or a person in place of the parent, or
3) less than 12 years of age and employed on the parent's farm, or with parental consent on farms not covered by the monetary provisions of the Act under the 500 man-day exemption.[28]

Under these provisions, most migrant parents can have their children legally working with them outside school hours. Only children under 12 may not work on a farm covered by the Act. Some state laws also prohibit child labor in agriculture. Twenty-nine states include a minimum age during school hours and 18 states completely exclude agriculture.

Most smaller farms employing migrants are still not adequately covered by any child labor laws. Preschool children are also not prohibited from the fields and the lack of child care alternatives reinforces their presence in a hazardous area.

The Sugar Act of 1948

This Act includes provisions that, in order to receive payment of an allotment, growers must pay their workers in full and at the minimum wage set by the Secretary of Agriculture unless they meet other statutory standards. The Sugar Act also states that in order to receive allotment payments children between 14 and 16 years of age, except those of the growers, may not work longer than eight hours a day. Violations will result in $10 per day being deducted for each child laborer in violation of the Act.[29]

LAWS RELATING TO WAGES, UNEMPLOYMENT, RIGHT TO ORGANIZE AND BARGAIN COLLECTIVELY

While small farmers and agribusiness are served by a variety of programs and legislation to ease their situation (e.g., crop insurance and price supports), the farmworker is excluded for no apparent reason. Agriculture is a hazardous occupation which is subject to uncertainty of employment due to weather conditions and readiness of the crops. This situation makes it difficult to predict employment, income, and working conditions. These conditions have not been addressed nor has an attempt been made to help ameliorate them at either the national or state level.[30] The Federal Equal Pay Act of 1963 prohibits discrimination in wage payments on the basis of sex but only applies to farmworkers covered by FLSA. As noted, the FLSA affects at most approximately 35% of the total migrant population. The National Labor Relations Act protects the rights of employees to organize and bargain collectively but agricultural employees are not benefited. In California since August 29, 1975, the current California Agricultural Labor Relations Act, extends the rights to organize and bargain collectively to farmworkers. Also, an Agricultural Labor Relations Board was created consisting of five members appointed by the governor. The Federal Unemployment Tax Act provides a small income to employees during periods of unemployment. Farmworkers, who could benefit the most from this coverage, are excluded except in Hawaii.[31] Workmen's Compensation Laws are state laws assuring that benefits be paid promptly to workers injured on the job. However, only 21 states and Puerto Rico provide some coverage in agriculture but only four of these treat farmworkers in the same manner as other workers. Farm occupations are the largest group that has been excluded from coverage.[32]

One law designed to aid farmworker employment is the Wagner-Peyser Act. This Act established a farm placement service, an employment system for farmworkers through the state employment service. It also sets minimum housing standards for workers recruited through this system, and requires that migrants be paid at the same rates as local workers. However, it has been reported that a number of growers in South Carolina refrained from using the State Employment office to hire migrant labor because they did not want to meet the housing standards required.[33]

Farmworkers have little, if any, legal recourse for demanding equal and fair wages in return for long, hard hours of arduous work. This lack of legislated wage and employment protection leaves the migrant family in an extremely vulnerable position. Migrants are vulnerable to abuse by employers, both crew leaders and growers, leaving them with wages so low that even if constant work were available, their earnings would still be below the poverty level. This problem makes child labor a necessity and affects the families' needs for services such as viable alternatives to child labor and leaving their youngest children untended at the edge of the fields.

Pesticide Protection Laws

Several federal laws have been enacted to curb the adverse effects of pesticide use in agriculture. The Federal Insecticide, Fungicide, and Rodenticide Act (FIFRA) controlled pesticides by requiring that rules for safe application be written on the labels of cans containing pesticides. The law was in effect from 1947 until 1972. These rules, however, were usually decided by the chemical manufacturing companies and were not effectively enforced. Provisions for safe use in the fields where migrants or others were working not the basis for regulation of pesticide use.[34]

After 1972, the Federal Environmental Pesticide Control Act (FEPCA) made it "unlawful for any person to use any registered pesticide in a manner inconsistent with its labeling." In contrast to the previous law, FIFRA, this law provided that penalties of up to $1,000 and one year in jail be applied to those not abiding by its regulations. This law also regulates the pesticides themselves by authorizing the Environmental Protection Agency (EPA) to cancel or suspend registration of chemicals found dangerous to the environment. Companies are also now required to give test procedures and results to the government for public disclosure. In addition, EPA is authorized to classify pesticides for general or restricted use. If restricted use is required the user must be certified. This regulation has resulted in protest from chemical companies and other agricultural interests. Strong pressure was exerted in 1975 for Congress to limit EPA's influence on banning potentially hazardous chemicals such as DDT. EPA now must consult with the Secretary of Agriculture before considering new regulations.[35]

At best, existing legislation provides minimum standards for protection from pesticides. In the "1976 Pennsylvania Farm Labor Plan"[36] it is stated that the same groups which have lobbied for weaker standards have also favored EPA's rather than OSHA's authority over pesticide use. Further, it is stated, "Regardless of EPA's good intentions, it has no mechanism [for workers to file a complaint] and is under constant pressure from agribusiness interests to deal primarily with firms rather than workers. Under such pressure, EPA recently cut off funds from a toll-free hotline program which permitted worker reports of pesticide incidents."

HOUSING

There is much documentation confirming the deplorable housing conditions in labor camps for migrant farmworkers. When housing is available it is clearly inadequate, unsanitary, and lacks the basic essentials for a decent environment. A recent report on the farmworker situation in the U.S. cites housing as the outstanding problem found in the study.[37] The problem is most critical in-stream where dwelling units are usually provided by the grower. Typically, these units consist of one small room per family, frequently without electricity or plumbing. Dr. Raymond Wheeler testified before a Senate Subcommittee on Migratory Labor that: "We saw housing and living conditions horrible and dehumanizing to the point of our disbelief...without heat, adequate light or ventilation, and containing no plumbing or refrigeration, each room (no larger than 8 X 14 feet) is the living space of an entire family, appropriately suggesting slave quarters of earlier days..."[38]

A study of migrant housing conditions in Kansas found that the number of individuals per housing unit was well above standard requirements. Ninety percent of the available housing was inadequate and did not meet minimum standards.[39] In rating the quality of the housing, it was found that 11% had visible defects but no major repairs were needed, 19% was fair with visible defects and major repairs needed, while 69% had visible defects and was far too deteriorated to repair. Growers often consider camp housing as part of the wage they pay the farmworkers.[40] This is sometimes recognized in a contract as a supplement to wages. With wages as low as they are, migrants must also pay for substandard living conditions unfit for habitation.

A 1974 study of migrant camps in Indiana also attested to the poor quality of migrant housing.[41] It found that occupants had to open sliding metal doors to get ventilation, urinals were not hooked up, there were large holes in floors, ceilings, and walls, and the water source was located in the middle of a hog pen. Much of this housing is very old, barracks from prisoner of war camps,[42] "renovated" chicken coops, and corn cribs.[43] Many migrants arriving in peak season do not even find shelter in the labor camps. They must sleep outdoors, in cars or trucks, and sometimes use bathroom and cooking facilities in the camp. This is the crowded and unhealthy environment to which the migrant child returns after school or after spending in the fields.

It is difficult to demonstrate a clear relationship between housing conditions and health due to confounding variables such as nutritional deficiencies. However, the conditions described here are known to contribute to disease, sickness, and the spread of infection. The American Pediatric Association has stated that "deteriorated housing is an essential feature of lead poisoning, and is related to the increased risk of accidents and the incidence of infectious diseases."[44] Clearly, many of these illnesses would be preventable if appropriate action were taken and regulations enforced. Nutritional deficits at birth and during development create a "high risk" category of children. These children, initially vulnerable to disease, then grow up in an exposed, crowded and unsanitary environment. Infectious diseases are a particular threat to migrants because of the crowded living conditions.[45] Immunization against these diseases is needed but many migrant children do not receive adequate preventive health care in the form of immunizations. On the other hand, some children who are attending school are brought to migrant health clinics in each new area of work and have been overimmunized due to inadequate record-keeping. However, the dangers of lack of preventive measures are far greater than any possible effects from overimmunization.

Environmentally controllable diseases prevalent in the migrant population include tuberculosis, lead poisoning, hookworm, and diarrhea.[46] TB is passed from person to person through the air. Quarantine and the elimination of overcrowding would help reduce its prevalence. Lead poisoning has been found in a large number of migrant children. This pediatric problem results primarily from young children's eating lead-based paint chips which can make them sick and disrupt the function of the peripheral nerves.[47] A study of housing and lead poisoning in upstate New York found that 98.3% of the labor camps had lead-based paint.[48] Several illnesses are related to the lack of proper body waste disposal and hand washing facilities. Hookworm is transmitted from the feces through the bottom of the feet and into the internal organs of the body. Improved sanitation and wearing of shoes would decrease the incidence of hookworm. In a California study the expected mortality rate from diarrhea was found, to be seven times greater for farmworker children than in the general population. This illness was studied because of its presumed preventability.[49]

In 1973, a typhoid epidemic occurred in a Dade County, Florida, migrant camp. Typhoid is an infectious disease easily transmitted through food and water. The cause was found to be an unprotected water supply at the camp; further, the design and construction of the camp wells and sewerage system had substantial flaws. A total of 225 cases of salmonella typhi infection was found. This was the largest outbreak of typhoid in recent history. As a result of this major outbreak, a Congressional hearing was conducted to investigate whether federal laws had been violated and how federal programs serving migrant workers were being administered. Congressman William D. Ford, chairman of the

House Subcommittee on Agricultural Labor, stated that, "Evidence presented before the Subcommittee indicates that workers are living in subhuman conditions, that very serious health hazards continue to exist, and that some federal laws and regulations are not being complied with."[50] After the outbreak the contaminated source of water was closed, water was piped into the camp, commercially, and a complete environmental study was done and recommendations made. The study was repeated a year later (1974) and it was found that none of the recommendations had been implemented.[51]

One may wonder how it is possible that such deplorable housing conditions can exist. What factors contribute to the existence and continuation of such labor camps? The growers who provide most of the housing complain that they are the only employers in America who must provide shelter for their employees. This is compounded by the fact that migrants only inhabit the camps a small portion of the year so camp owners feel it is not economically feasible to maintain decent housing.[52] Communities view farmworker housing like other low-income housing: it lowers real estate value and increases tax burdens.[53]

In theory, migrant families should be provided with safe, healthful working conditions under the Occupational Safety and Health Act. Housing, therefore, must meet OSHA standards. OSHA legislation which should protect the migrant family from environmental health hazard is described below.

Occupational Safety and Health Act (OSHA), 1970

OSHA was first enacted in 1970 and empowers the Secretary of Labor to issue mandatory safety and health standards for industry and agriculture. For agriculture this includes both the sanitation of labor camps and pesticide protection. In 1972 provisions were made for federally authorized inspection of employee housing. However, this applies only to farms employing 500 or more persons during the year. The regulations also provide that OSHA standards will apply unless a state or local law or regulation has more stringent standards. Each state submits a plan to the U. S. Department of Labor (DOL) which contains its requirements for occupational safety and health. DOL then may grant approval of the plans.

Complaints may be filed by any farmworker or representative, such as the local farmworker organization, if a violation is believed to exist. Then, the area director for OSHA will make an inspection if he feels it is necessary. If the result is not satisfactory, an appeal can be made to the OSHA Regional Administrator. Retaliation by employees or crew leaders against the worker or representative is prohibited. Area directors are "given a great deal of discretion to determine the penalty for any violation."[54] There are no penalties for minor violations and the following factors are considered when penalizing a major violation: size of the business, gravity of the violation, good faith of the employer, and history of previous violations. A reasonable time is then fixed for correcting the violation.

While a national effort toward improving working conditions is necessary and laudable, this particular legislation has proven more harmful than beneficial for the migrant population. The primary reason for this is that a threat of increased strict inspection has resulted in the closing of migrant labor camps. Rather than make costly repairs to bring the camps up to standard, growers have chosen to close the camps. It has been reported in a national study for the Community Services Administration that housing has been reduced by perhaps one-third as a result of OSHA regulations.[55] A participant at a regional conference held as a part of this study stated, "I am not sure that a seven-month pregnant woman is any better off in a car than she would be in a house that may not have had a bathroom." OSHA has provided no alternatives, such as requiring repairs, rather than closure of camps.

Other problems with OSHA's enactment have been:

- Lack of comprehensive enforcement; some states have their own housing regulations and it has been unclear who is responsibilie for inspection.
- Insufficient staff to effectively enforce all requirements of the Act.
- Regulations have been in the draft stage. No final version with the force of federal regulations had emerged before 1976.[56]
- It is permissible for inspections to take place before the camps are occupied. If not, the migrants are there too short a time for re-inspection and growers may then keep putting off repairs until the next season. Also, once workers are occupying the camp violations can be declared as caused by the workers. This makes applying penalties controversial and harder to justify. A New Jersey Superior Court has ruled, however, in the case of 5 Migrant Farmworkers vs. Hoffman, August 26, 1975, that pre- and post- occupancy inspections can be made.[57]

It is clear that the overall environment and lifestyle of the migrant family is far from optimal. Legislative protection is sparse and poorly applied, and provision of services is inadequate when considering the severely detrimental factors that make up the child's environment. Considering these factors, why do people migrate and how does this environment affect the mental health of migrant children and their families?

MENTAL HEALTH

Robert Coles has said that, "It is a particular kind of social and economic system that permits, even encourages migrant farmers to wander, wander the land..." Coles also mentions that too often psychiatric workers look at "minds," "cultures," or "social systems" without asking themselves "the plain facts about who is running whom, who owns what, who hires which people for what purpose, who prevents what families from living here, settling down there, working at this kind of job, or indeed working at all."[58] These social and economic influences are important and controlling factors in the mental health and welfare of migrants. Migrant farmworkers are caught in a cycle of poverty and agricultural work where migration is due to economic pressures. Approximately one-third of the migrant work force needs to travel beyond the borders of their home state in order to survive.[59] Labor-intensive crops often require more workers than the local labor market can supply at the wages offered.[60] Arrangements for more and cheaper labor are then made directly, or most frequently, through contractors or crew leaders. The migrant family becomes very dependent upon the crewleader for loans and future work. Because of this dependence, abuse and exploitation, such as not reporting social security deductions, are common. These injustices either are not recognized by the migrant family or are endured because the crew leader is needed.

A continual high stress situation may lead to mental health problems for many people. Dependence, exploitation and poverty are a few of the variables found in the migrant world which have been called "stress indicators." Another variable often creating stress is discrimination. Migrant family members may be victims of discrimination due to their race or low socio-economic status. Indeed, discrimination can result in economic deprivation, harrassment, and inferior educational opportunities.[61] Movement itself from area to area creates an unstable, unpredictable lifestyle which is a potential source of stress. Migrant life in rural areas is isolated, and typically migrants remain far from the rest of the community and lack transportation. The migrant family wishing to settle out of the stream or take part in various training programs may be undergoing a process of acculturation. This process can involve a variety of new and different experiences with which the migrant may not be ready to cope. All these factors would create a highly stressful situation for a great many people; however, whether this leads to mental health problems in the migrant stream has not yet been documented. It may be that the levels of expectation in the migrant population differ so that these "problems" are not viewed as unusual, or even defined by them as problems. From birth the migrant child must adapt to different situations, and this unstable stressful environment is the norm for them. The extent to which this affects the mental health of the migrant child needs to be investigated.

Federal funding for mental health programs is available primarily through Title XX of the Social Security Act, described in Chapter IV, and the Migrant Health Act. It would also be possible for health clinics and hospitals to apply for special grants from a source like Rural Health Initiative (RHI) of the Public Health Service, Department of Health, Education, and Welfare. This provides funding to supplement health services in rural areas. Additional counselors could be funded by this program so long as they would be available for all those who needed service rather than just for a specific population.

As with the delivery of other health services, the delivery of mental health services would involve the same, or similar, problems when concerned with the migrant population. Lack of continuity of care, especially important in mental health counseling, is again a problem with such a mobile group. Access to mental health workers in rural, isolated areas is still an obstacle, as is availability of appropriate services and their acceptability to the migrant family.

The response to mental health problems may also differ for migrants as compared to other groups. This may be seen by the underutilization of mental health services by migrants. The cultural background provides one set of possible responses to more "traditional" forms of treatment. Migrants usually have an extended family structure, as described above. Instead of turning to an "outsider" for assistance, they frequently bring problems to other family members for help. If a migrant does not turn to the family for help it may look as if the family was not trusted or that the person was rejected by the family and must go outside for assistance.[62] This built-in support system of the extended family may decrease the frequency and severity of reported mental illness.[63] Priests or other religious and community leaders are often sought out rather than mental health workers in a clinic. In addition, the practice of folk medicine in the migrant stream leads to the use of curanderos or folk healers to help with problems.[64] The use of these alternative systems for alleviating stress or other problems may significantly decrease the use of social workers or other counselors.

Continued use of these alternative systems is logical since turning to others of the same culture, language, and value system, especially when isolated geographically, is likely to be more comfortable and result in better understanding of one's problems. Also various institutional policies may discourage self-referrals and continuation in counseling once referred.[65] Many clinics are staffed by White professionals rather than persons of the same ethnic background who are familiar with the migrant lifestyle.

While very little research has focused on the mental health of migrant children, the measurement of "intelligence" through tests is one of most common methods of assessment of any population. Applying this to migrant children raises the same objections as with Black inner city children or those raised in cultures or settings different from that in White middle class homes. There has been much discussion in the past few years of the lack of culture-free testing. A study by Cook and Arthur[66] compared the results of administering the Stanford-Binet I.Q. test with results of administering the Arthur Point Scale of Performance test to 94 Mexican American migrant children over 5½ years old. The Binet I.Q. was 84 while the Arthur Point Scale I.Q. was 101. Rather than concluding general retardation, as indicated by the Binet scores, the significant difference in the two average scores is likely due to the Binet being inappropriate to tap the abilities in this population. The vocabulary of children is culturally and situationally determined.[67] While a migrant may not be familiar with the language or objects in middle class homes, the migrant child does know the language heard in the fields. This low fluency in certain situations impairs intelligence test performance and often results in poor grades at school.

The incidence of mental health problems, types and severity of problems such as mental retardation, have yet to be documented. As with measuring and studying other aspects of migrant life, mobility and isolation make the collection of data difficult. However, the existence of more mental health programs appropriate to the migrant population (e.g., with counselors and other professionals of the same background) may increase their use and encourage assessment of need in this area. Programs building on rather than ignoring the culture of those needing services have been suggested for the Spanish-speaking population.[68] Certainly it is more than appropriate to apply this premise to programs for the entire migrant stream.

CHAPTER III

ELEMENTARY AND SECONDARY EDUCATION

Many barriers exist to properly educating migrant children, at both the elementary and secondary levels. While the barriers may be different for each age group, they stem from the same conditions: the migrant's occupational mobility and economics, poor community response, and inadequate school resources. Although these barriers are formidable they are not insurmountable, and in fact the educational situation has been improving in the last two years.[1] This chapter describes the barriers that exist and the legislation and programs that are designed to overcome them.

As discussed in the previous chapter, the migrant family's income is usually well below poverty level. This makes it necessary for many school-age children to work in the fields rather than attend school. Some children both work and go to school, which makes for a long, tiring day and makes absorption of academic materials difficult. Another major barrier to attendance is the necessity of older children to care for their younger siblings where day care services are not prevalent.[2] There have also been many instances reported of migrant children being sent home because they were not wearing appropriate clothing, or not attending school because there were not enough shoes or underwear for everyone in the family.[3,4] Additional expenses incurred for transportation, if it can be provided, and fees for special classes, gym clothes, books or extracurricular activities can make the cost of attending

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school prohibitive for any poor person. Illness of course, further reduces the amount of time migrant children spent in school. And the poverty of most families, with the resulting poor nutrition, make migrant children more susceptible to childhood illnesses.

Once migrant children are in the classroom, parental and teacher response to their education is an important factor in their continued attendance. While many migrant parents want their children to have a good education and are concerned about school performance, they have little time or energy to devote to school programs. Distance from a school and lack of transportation prevent them from visiting the school, especially during school hours - when they must work. Many educators and community residents do not understand this and feel the parents are apathetic about their children's education.[5] Some parents, to ensure that their children get an education, leave them in the home-base with friends or relatives while they migrate. At times, the mother may stay with the children so they can attend school while the father goes "on the stream" to work, thus disrupting the family unit. For American Indian migrants, participating in their children's education is difficult indeed. Many of these parents must send their children to government-operated boarding schools and, therefore, have no contact with the school or their children for long periods of time.[6]

Most migrant parents themselves have had a poor education with irregular attendance at school. They know that education is important but feeding the family must come first.[7] This too, influences their participation in their children's education. School-age children whose parents had less than eight years of schooling are four times as likely to be out of school as those whose parents had a college education.[8] In addition, teachers and school officials in many areas are not ethnically representative of the migrant community and the curriculum is often oriented to white middle-class values and experiences. This makes school an alien environment for migrant parents as well as for their children and can make the parents distrustful of "outsiders" teaching their children.

Teachers in the local community are often unprepared for the influx of migrant children at different times each year. When migrants do attend school it is almost always in rural areas. In general, rural areas have fewer educational resources, than do more urban areas, as well as fewer vocational and technical schools, poorer buildings, and lower paid teachers.[9] These schools are ill equipped to provide counseling and social services. In addition, community response to providing quality education for migrant children has been poor. Many local people feel that it is not their responsibility to care for these children, despite the contribution migrants make to the agricultural resources and income of local families. They are also seen as a temporary problem that will go away. Only the promise of federal money and allowing local children to participate in special programs has spurred interest in serving migrant children. And many teachers are resistant, along with local residents, to integrating children with special needs into the regular classroom because most teachers have no special training and little extra time to aid new children. Most schools, then, cannot provide the financial resources, classrooms, special teachers, or necessary transportation to properly serve migrant children unless enough federal support is provided.

Frequently, much time is spent testing the children when they enter a new school so that teachers "know where to place a particular child." While this information could be used to provide an individualized approach to teaching and help maximize the learning experience, the method of assessment used by many teachers has come under sharp criticism. Standardized tests are frequently used which are culturally biased. The content of these tests was developed with the dominant white culture in mind and reflects an environment foreign to the migrant child. It is no wonder that migrant children do very poorly on tests that do not show what they have learned about their own culture, language and migratory environment. The child of limited English-speaking ability has even more difficulty in performing well on culturally-biased tests. Too often results of these tests have been used to label migrant children as retarded or place them in slow learner groups. Another problem arises with pre-post tests, which have been used to measure academic improvement while the children are enrolled. Migrant children are rarely in a school long enough for these tests to serve as a valid assessment of their progress. It may take several weeks for them to adjust to a new school and begin to learn the material being presented. And frequently they must leave before the post-test is administered.

Children from extremely poor families, such as migrants, tenant farmers, and Appalachians, have long been victims of discrimination because of their low socio-economic status, especially when outside their home environment and among those who are more fortunate. Those migrants who are minority group members, like Blacks, Chicanos and Indians, have racial discrimination to add to their early experiences. For them, school has not been a pleasant, healthy place to be. In the past they have not even shared the same facilities as the majority of children. For example, in the rural south, where many Black migrants live, Whites have traditionally received the most funds for public education.[10] This priority has continued through recent years. Also in the rural south, college preparation has been stressed in the curriculum rather than vocational education which may, for those whose stay in school is limited, be a more viable alternative.[11]

For Chicanos, speaking a different language has highlighted their appearance as "different" from the other children. Chicano children bring to school with them a different culture - something that could benefit all students. However, in the past their cultural heritage has been looked on as a handicap, something to be ashamed of, a condition to be corrected. Many states, even today, require that only English be spoken in the public schools.[12]

Encouragingly, a new emphasis is being placed on bilingual/multicultural education.[13] The need to capitalize on the cultural richness in the nation is beginning to be recognized at the federal level and also in some states, according to the National Advisory Council on Bilingual Education.[14] Yet bilingual education remains a new field with limited funding. The need for these programs, however, continues to be great. There are in the nation approximately 481,000 children 4 to 5 years old and 3,118,000 children 6 to 18 years old who have limited English-speaking abilities.[15] In the migrant stream the majority of children are Mexican Americans, whose dominant language is Spanish. The Commissioner's Report on the Condition of Bilingual Education estimates that 78,283 bilingual teachers in the Spanish language group are currently needed at the elementary level. There is also a great need for bilingual instructional materials, although the need for those in Spanish is not as great as for those in smaller linguistic groups. To help fill these needs a National Clearinghouse of Bilingual Education may be established soon by the Office of Education and the National Institute of Education. It would collect, analyze, and disseminate bilingual education information to those needing it.[16]

Further development of bilingual/multicultural education is necessary for the provision of quality education for a great many migrant children. To make educational programs truly successful for these children, and all migrant children regardless of race, the curriculum must be functionally related to their own life experiences and help them to manage the environment in which they must live. Pride in their own culture and knowledge of their heritage is a most important part of this.

Migrant children suffer from the conditions that have been discussed both at the elementary and secondary levels. In addition, those who manage to reach the secondary level do not find the going easier but more difficult - as additional pressures bear down on them. There are, of course, the accumulated effects of years of discrimination, alienation, and assumed failure in the school environment. There is also the increased desire and necessity to work to increase the family's income as the student grows older.[17] With the greater responsibilities of age, secondary students find themselves having to "catch up" rather than simply continue, since their early education has not prepared them for what is now expected of them. Their need is for special assistance to enable them to take part in the opportunities offered at the secondary level. But the assistance is not often there, because the federal and state programs that offer them hope are concentrated elsewhere - at the elementary level they have just left.

One result of these pressures is reflected in the chart below, which shows the distribution of migrant students by grade level.[18]

DISTRIBUTION OF STUDENTS BY GRADE LEVEL

(Migrants vs. National Average)

	Percent Distribution		Difference
Grade Level	Migrants	US Total	(Migrants - US Total)
Pre-Kindergarten and Kindergarten	7%	6%	+1%
Grades 1 to 6	71%	50%	+21%
Grades 7 to 8	14%	16%	-2%
Grades 9 to 12	8%	28%	-20%
	100%	100%	

Source: InterAmerica Research Associates
An Assessment of the Migrant and Seasonal Farmworker Situation in the U.S. for the Community Services Administration.

Many vocational training programs required a tenth grade education, but, as can be seen in the chart, few migrant students stay in school to qualify for these programs. The sharp decline after sixth grade is evidence that the education provided is not appropriate for their needs.

MAJOR FEDERAL LEGISLATION RELATING TO ELEMENTARY AND SECONDARY MIGRANT EDUCATION

Elementary and Secondary Education Act (ESEA) 1965, Title I Educationally Deprived Children, (20 C.F.R. Part 116d)

To change the educational situation, to motivate migrant children to become productive students and thus productive adults the educational system must recognize their cultural backgrounds and their occupational and personal goals. The federal and state efforts that are taking place to foster this recognition and meet the special educational needs of migrant children are reflected in the programs and fundings sources described below.

This Act is the primary source of funding for migrant education programs. It authorized a national education program for disadvantaged children and was amended in 1966 to include special provisions for children of migrant agricultural workers. As of 1975 this also includes children of migratory fishers and children whose parents have settled out of the migrant stream for up to five years. Currently, the Title I migrant program serves 347,700 children.[19]

Under the Act, each State Education Agency (SEA) prepares a state plan including a cost estimate for migrant education according to the guidelines set up by the Office of Education. Once approved the grant is allotted directly to the State Department of Education which then provides the Local Education Agencies (LEAs) with funding to run their individual programs. The total amount of money allotted to each state is determined on the basis of a formula estimating the number of migrant children in each state and per pupil expenditures. The counting of migrant children is, therefore, very important but primarily because of their mobility, this has always been difficult. Department of Labor estimates were used initially but were found to be inadequate.[20] In 1970, the Migrant Student Record Transfer System (MSRTS) was developed. This is a national computerized system which maintains and distributes to LEAs the educational and health records of all children eligible for benefits of this program. An "Evaluation of the Migrant Student Record Transfer System" was conducted by the General Accounting Office which compared the quality of data from MSRTS and the Department of Labor. The findings led to the use of MSRTS statistics for estimating the number of migrant children in each state. Funding is now based on the number of "full-time equivalent (FTE)" children in a state, not on their enrollment in school. Allocations were first made on this basis in FY 1975 and FY 1976.

The Title I migrant program has grown tremendously since its inception. It provided $10 million in 1967 to 44 participating states. In 1976, this had increased to $97 million dollars and included 48 states and Puerto Rico. For fiscal 1977 states are receiving $130,909,832 for migrant education.

The Title I migrant projects can provide comprehensive programs for migrant children which include instruction, support services and preschool care designed to meet their special needs. In addition, the MSRTS is available to aid in continuity of education and health care while home base or in-stream. The educational instruction program gives special attention to the development of language arts including reading, speaking, and writing in Spanish and English. Funding for support services may be applied toward aiding their general health and welfare "to enable effective participation in the instructional services that are designed to bring about an improvement of educational performance." These support services usually are in the areas of health, nutrition, psychological services, cultural development, pre-vocational training and counseling.

Day care for infants and very young children may also be provided but only on a very limited basis since funding is based on the number of FTEs for 5 to 17-year-old children. It may only be provided to enable older siblings to attend school and a special application to the Commissioner of Education must be approved. Generally, day care is provided if it is not available from other public or private agencies, and if it is essential to allow eligible children to participate, and is not extravagant. A preschool program may be financed by Title I migrant funds but only if it does not detract from the program for school-age children. The emphasis in this program is on elementary-aged children. Additionally, acquisition of equipment and transportation and, if necessary, construction of school facilities may be financed to ensure operation of the program.

Parental involvement in planning and implementation of the program is encouraged. Advisory councils consisting of parents and professionals knowledgeable about migrant education are to be set up in each project. The school consults the council concerning project development and all aspects of the program. Obviously most migrant parents are not in the area long enough to adequately serve in setting up the program. However, they are encouraged to be in contact with the school to the extent possible.

The State Education Agency is responsible for initial program development and needs assessment in order to apply for funds. The SEA must also ensure that LEA programs comply with the state migrant education plan and must provide technical assistance to the LEAs when needed. Annual state program evaluations and fund accountability reports are prepared by the SEA. A statewide recruitment and identification program is also run at state level. This is to ensure participation of all eligible migrant children including former migratory children (up to five years after their parents have settled in one place). In addition, the SEA is responsible for interagency coordination and ensuring that the MSRTS system is utilized.

Several evaluations of the Title I migrant program have been conducted in the past few years, and many problems have been uncovered. Some of these have been corrected while others still need attention. A very thorough evaluation was conducted for U.S. Office of Education by the Exotech Corporation in 1974.[21] Some of the shortcomings identified were:

- no standardized measures were being used for evaluation of individual gains or for placement purposes
- less than 1/3 of the programs provided extended day services and many terminated their summer program when a need for services was still evident
- only 17% of the home-base area project directors and 11% of the in-stream project directors indicated that preschool care was provided
- less than 1/4 of the projects provided individual counseling
- only 43% of the project directors in home-base areas and 39% in in-stream projects indicated that bilingual education was available to all children

- only 50% of the teachers and 87% of the classroom aides were fluent in the children's native language
- vocational training resulting from the Title I program occurred in only 21% of home-base area projects and 41% of in-stream projects
- 1/3 of the students indicated that they had received no medical or dental examinations

These data indicate that, while a wide variety of essential services can be provided with Title I funding, there is relatively low provision of services outside the regular instructional program. Certainly in the areas of preschool care, extended day services and vocational training, it is much short of an optimal situation.

Despite the problems found in the program, the Exotech study concluded that the program did pave the way for developing greater continuity in education for migrant children. It further stated that "discontinuation of Federal migrant monies would immediately dispossess the migrant children of their opportunity for equal education."[22]

The Title I migrant program has also been criticized for a lack of accountability of allocated funds.[23] According to a joint statement by Miriam Guido, former MLAP attorney, Jeffrey Newman, Director of National Child Labor Committee, and Ronald Brown, President of NCLC's Board of Trustees:

> In many states Title I funds earmarked for the education of migrant children are swallowed up by bureaucracies, misspent, or never spent at all, thereby violating the intent of the law, as well as ignoring the needs of the children. Migrant parents, with little or no political base from which to operate, with little or no representation on school boards and in legislatures, have had no recourse for change.[24]

For example, the current Pennsylvania Farm Labor plan found that per pupil cost for the state's migrant summer program was as high as $1,000 not including administrative costs and services. They stated that this exorbitant cost meant that the state was either receiving funds it was not entitled to, or the children were not being served on an equitable basis. After comparing the estimates of those served with the number actually served the report concluded that it was unlikely that anything like the estimated number was served.[25] Accountability problems such as these are partly due to the fact that regulations lack specificity in requirements for program evaluations. Each project evaluates itself and the SEA then prepares a state program evaluation. This is not an objective enough analysis to judge the program.[26] However, no uniform objective measures of program success are available at the national level. The audit agency of HEW reported in 1972 and again in 1974 that state evaluations are either absent, incomplete, inaccurate or late.[27] The most current program evaluation has been conducted by the National Child Labor Committee with results to be released in January 1977.

Another aspect of the program is the Migrant Student Record Transfer System which receives a portion of Title I funds each year to ensure its operation and to train terminal operators and school personnel to use the system. All participating Title I schools use a uniform migrant student transfer form for family background and educational data, as well as a separate medical history form. When a child enters a new area the school requests the child's records from the main computer in Little Rock, Arkansas. The system can transmit the complete forms within four to twenty-four hours. When the child leaves a project area it is the responsibility of the teachers to enter the most up-to-date information on each child and send this back to Little Rock so that it will be available when the child is enrolled at the next school.

The Exotech study, conducted after only a year of MSRTS operation, found a very high percentage (90%) of overall usage of the MSRTS system in the projects surveyed. However, only 56% of the teachers actually used the MRTS information. Some teachers said the information arrived too late to be helpful or did not arrive at all; others said they preferred their own evaluations, and a few felt that the information was not useful or reliable.

A National Benefits Assessment of the MSRTS system was conducted in October 1975 by D.A. Lewis, Inc. They found a very high familiarity with and usage of the system in receiving states.[28] However, they found that western stream project personnel were not effectively using the system while eastern stream personnel were utilizing it quite well. Part of the reason for this may be the inadequacy of proper training. Less than half the teachers surveyed in this study had received in-service training. Yet, three out of five persons surveyed reported that they had seen benefits from the MSRTS, and it was found that administrators and nurses had made good use of the system.

The MSRTS system allows a fairly accurate count of the number of migrant and seasonal farmworker children as well as former migratory children for up to five years after settling-out of the stream. Being able to trace children from one area to another has been shown to be advantageous. In 1973, it was used to find more than 200 children who may have been exposed to typhoid fever in Homestead, Florida.[29] The data bank traced the children to other parts of Florida and Texas.

Concern was raised last year by the National Committee for the Education of Migrant Children about the purpose and function of the system.[30] The most important issue raised was confidentiality of information - whether the system safeguards the privacy of the child and whether parents have approved data kept on their children. In a position paper, the Committee stated that too much emphasis was being placed on MSRTS and not enough on other important areas like staff development.

Because there is little concern nationally for the migrant constituency, a great deal of political maneuvering has been needed to ensure the continuation of the Title I Migrant program. As has been noted by William D. Ford, Chairman of the Subcommittee on Agricultural Labor of the House Committee on Education and Labor, "it is just not a program that turns a lot of people on because there is not anybody out there with voting power."[31] Yet its value remains, for, as Ford declares, "there is no other compensatory program that supports the state at the federal level and this is without state or local advocacy."[32]

Elementary and Secondary Education Act of 1965, Title VII Bilingual Education

The Bilingual Education Act was established in the 1968 amendments to ESEA. This new legislation was designed to explore novel educational approaches to meet the needs of children of limited English-speaking ability. Further ESEA amendments in 1974 broadened the Act and encouraged further development by appropriating additional funds. At present the legislative basis for bilingual education lies in this legislation and in the Civil Rights Act of 1964. A landmark decision under the Civil Rights Act gave great impetus to bilingual education. This was the Lau v. Nichols Supreme Court decision in 1974, which held that the San Francisco school system was violating the Civil Rights Act by not providing English language or other adequate instruction to 1,800 Chinese American students.[33] It was held that students who do not speak English were denied meaningful participation in the school program. As a result, school systems receiving federal funds must comply with the Lau decision if the district has twenty or more students of the same non-English home language.

The philosophy of the instructional approaches used in bilingual education is stated by the Office of Bilingual Education as:

> the Bilingual education technique makes use of two languages, English, and the one the child uses at home. This approach does not simply involve translation, but rather uses the languages interchangeably, one at a time, often at a different time of the day. The student drills in listening, speaking, reading, writing, and other academic skills, and learns the history and culture associated with both languages, acquiring the skills and knowledge necessary to academic development and progress, regardless of language. This does not suggest that it is to be considered as a compensatory effort. It does suggest, however, that instruction in English as a second language is a necessary part of instruction but is not sufficient to establish an educational program. A bilingual education program recognizes the need to develop and maintain native language and cultural skills, it values language as a transmittal of culture. Thus, it is believed, the child progresses at the same pace as English-speaking children but without the devaluation of his/her culture and self-concept, developing both linguistically and cognitively.[34]

The growth of bilingual education in the last few years is evident in the sharp increase in federal appropriations. In fiscal 1973, $33.2 million was appropriated; this increased to $97.8 million in 1976 and $115 million in fiscal 1977. In addition, a National Network for Bilingual Education has been established which includes nineteen centers around the nation. These centers are of three types: materials development, resource training, and centers for assessment and dissemination of materials.

Bilingual education funds from Title VII are provided as grants to Local Education Agencies (LEAs). Applications for these funds are submitted in the form of project proposals to the Commissioner of Education and the State Education Agency, which serves in an advisory capacity. Funds may be appropriated for research, pilot programs, development of special instructional materials, training, provision of bilingual instruction, and bilingual activities in trade, vocational or technical schools.

It is not clear how many migrant children are being be served by bilingual education programs. Most Title VII programs are focused on urban, inner city children while migrant children, except settled-out migrants, are generally in rural or small town areas.[35] It was noted at recent public hearings held by the National Advisory Council on Bilingual Education that it is difficult to qualify for Title VII funds unless a high concentration of children of limited English-speaking ability can be shown within the school district.[36] While scattered populations in rural areas or migrant populations that are only present for a few months of the year are in need of the services provided by this legislation, the regulations do not deal effectively with their special needs. It was suggested at the hearings that funds be earmarked for the migrants' bilingual needs or that funds be provided for vehicles to transport a mobile teaching staff.

Comprehensive Employment and Training Act (CETA), Title III-B

CETA is primarily concerned with manpower training and has set-aside funds to operate programs for migrant and seasonal farmworkers under section 303. Its purpose is two-fold:

1) Provision of services to migrant and other seasonally employed farmworkers and their families who wish to seek alternative job opportunities to seasonal farmwork.

2) Provision of services necessary to improve the well being of migrants and other seasonally employed farmworkers and their families who remain in the agricultural labor market.[37]

CETA is included in this review because some older youths may be able to participate in the educational training programs funded by this Act. Classroom training, on-the-job training (OJT), and work experience with a nonprofit agency are all provided to "enhance the employability of individuals by upgrading basic skills."[38] Remedial education and English-as-a-second-language (ESL) programs, therefore, are provided to help applicants gain entry in other 303 training programs (most of which require at least a tenth grade education).

One program in particular is designed to help migrant farmworker adolescents finish high school by gaining a General Equivalency Diploma (GED). This is the High School Equivalency Program (HEP). It was originally an OEO program that was transferred to the Department of Labor in 1973. The goals of the program are to aid students in obtaining the GED in order to place them in college, advanced vocational education, or directly into a job.[39] HEP graduates are also given priority for entry in the CETA-sponsored College Assistance Migrant Program (CAMP).

Applicants for HEP must be 17 to 24 years old, unmarried and have incomes below poverty level. Once in the program they receive free room and board at one of the colleges or universities sponsoring the program, and $10.00 a week pocket money. HEP classes are limited to ten students each, to allow for maximum individual attention.

The success rate for this program, especially considering the population served, is very high. Most students do not continue through the program without interruption, but leave to migrate with their families or for other reasons. Most students return to complete the program, however.[40] In one year (September 1972 to August 1973), 31% of the 1,500 students enrolled went on to college. And most of the 1,500 received their GED or were placed in a job. Only 270 dropped out of the program.[41]

The limited funding for this unique program has been tentative for the last year. It was recently refunded only through FY 1977 at the 1976 level. It is currently being determined whether the HEP and CAMP programs should be administered by the Office of Education rather than the Department of Labor, which requested no funds for the program this year.

Other federal funding sources that may possibly be serving the educational needs of migrant farmworkers include the Emergency School Aid Act (ESAA), the Vocational Education Act of 1963 and the Right to Read Program. There are no data available on whether migrants are benefiting from these programs, because no part is devoted only to service for migrants. A short description is provided here because the benefits of these funds could potentially aid the migrant educational situation.

The Emergency School Aid Act was authorized in the Education Amendments of 1972 under Title VII. Its purpose was to ease the LEAs' financial strain in reducing minority group isolation. In FY 1975, $215 million was distrbuted to 829 projects to "reduce segregation, discrimination, and minority group isolation, and to assist minority group children to overcome the educational disadvantages of that isolation."[42] Of this amount, $9 million was set aside to assist children whose linguistic status has denied them equal educational opportunities. Bilingual education programs were provided, therefore, to elementary and secondary school children.

The Vocational Education Act of 1963 has as a national priority a 20% set aside of funds for the disadvantaged and a 5% set aside for students of limited English-speaking ability. Its overall purpose is to provide part-time employment for those who need earnings to continue training, vocational guidance, and counseling. Title VIII, Part D, Section J of the Education Amendments of 1974 to this Act deals with bilingual training. Realizing that the entry of those of limited English-speaking ability to the labor force is inhibited, $2.8 million was appropriated in 1975. Training was received by a small number of students (3,250), from five different language backgrounds. It is conceivable then that a few migrant youths may be receiving vocational training through funds provided under this Act.

The Right to Read Program was authorized under Title VII of the Educational Amendments of 1974. Its purpose is to strengthen elementary school reading programs as well as to promote literacy among adults. Financial assistance is given to LEAs and SEAs to develop innovative reading strategies in this area. Out of $12 million dollars appropriated in 1975, $946,000 was spent on bilingual and English-as-a-second language programs. Parents, community members and volunteers in reading assist in this effort toward eliminating illiteracy in the U.S.[43]

The number of migrants benefiting from these programs is not known. However, the funds are available to them - either as part of a disadvantaged group, minority group members, those in need of bilingual education, or secondary students needing vocational education.

SERVICE DELIVERY AT STATE AND LOCAL LEVELS

The states' commitment to migrant elementary and secondary education is primarily through administering federal funds like the Title I migrant program. Advocacy for migrant education is very limited at this level because few states have funds allotted for special migrant programs.

In recent years state governments have begun to endorse bilingual education programs which may be reaching the migrant population.[44] In 1971, no states required bilingual education. Thirteen states, in fact, required that only English be spoken in school. Presently, eleven states have prohibitory laws mandating English instruction only, while other states have made strides in a positive direction, primarily since the Lau decision. Among the eleven prohibitory states are North Carolina and Iowa, which do have significant migrant populations. Ten states require that bilingual education be provided under certain circumstances. Fifteen states currently recognize and permit bilingual education. In 1974-1975, $38,111,938 was spent by the states in support of bilingual education; however, this monetary commitment varies widely from state to state.[45] Most states are not allotting any funds. Below is a listing of state statutes that may provide funds for educational programs for migrants, or from which migrant children might benefit.[46]

California: Individual counties can provide emergency school transportation and teachers for migrant laborers while they are working in the state. State aid is also available to impacted areas but only when funds are not available from other sources or when the county superintendent of schools deems it necessary.

Colorado: The State Board of Education can administer a migrant education program with school district and state funding. Additional teachers, supplies and bus transportation are included. In addition, summer school for migrant children may also be provided entirely by state funds.

Florida: A waiver of tuition is given for the children of migrant laborers not officially residing in the state.

Illinois: Compensatory education programs for the "educationally disadvantaged" are provided supplementary to regular public school programs. Migrant children may qualify as educationally disadvantaged in Illinois. The funds are given to encourage the local school districts to develop these programs.

New York: The Commissioner of Education may grant additional aid for summer school programs for migrant children. Local school districts may also get aid to help defray additional costs in migrant areas. No more than $300.00 to an individual district can be provided.

Oregon: Approved summer school programs for migrant children can be supported entirely by the state.

Texas: Additional aid for the educationally handicapped is provided under the Texas Foundation School Program. Ages five to twenty-one years are eligible and kindergarten may be run for a full day during one semester.

SPECIAL PROGRAMS

The California Migrant Teacher Assistant Mini-Corps program began in 1967 as a part of the California Title I Migrant Education Plan. It is sponsored by the State Department of Education, Bureau of Community Services and Migrant Education. The program was developed because of the great need for teachers who could communicate and relate culturally to the migrant child. Indeed, teachers whose background was similar, and who were familiar with the special problems encountered by migrant children were needed. Teachers who had once been migrants themselves could be trained to meet this need. The long term goal of this program is to "increase the number of professional educators who are especially trained, experienced and committed to work with migrant children."[47]

To qualify to enter the Mini-Corps program a student must be enrolled full-time in an institution of higher education, need financial assistance to continue education, be bilingual in Spanish and English, have knowledge of the migrant family life-style, and be dedicated to teaching migrant children.[48] Once these qualifications are met and the students are enrolled they are granted a stipend according to the number of weeks spent in service to migrant children. The program pays room, board and tuition while on campus and lodging while in the field.

The training program consists of a seminar course which is a one-week orientation to problems of migrant families, to community agencies, and teaching techniques. The students then work as teacher assistants in a summer classroom for six to nine weeks. A one day post-service evaluation is then held. For this work, in addition to the stipend, the students receive three units of college credit. During their work weeks the Mini-Corps persons actually live in the camps and get to know the families and encourage the participation of the children in an educational program. Four colleges now have training programs and sites for the Mini-Corps teacher assistants. These are California State at Chico, Bakersfield, San Diego, and Indio.

Not only does this program increase the number of teachers trained to work with migrant families, but the students also serve as excellent role models for the younger migrant children. Recently, a school year program, a medi-corps (para-medical trainee) program, and an administrator trainee program have been added to Mini-Corps. Mini-Corps is one program that could easily be expanded for use in many migrant labor areas.

Learn and Earn is a program run by the Florida Migratory Child Compensatory Program funded by Title I migrant. It began in 1970 as the result of a study conducted in Florida by Dr. E. John Kleinert at the University of Miami. The study showed that the conventional curriculum was not appropriate for migrant children.[49] Further, the study suggested that a curriculum geared more closely to a mechanized rural economy and urban settings would be appropriate. Skill training beginning at the elementary level and work-study programs at the junior high school level were recommended due to the high drop out rate for this age group. Work-study would allow students to earn needed money yet stay in school part of the day.

The early program was intended to teach employable skills and pay students a stipend to work on campus to satisfy their financial needs. As the program developed it shifted emphasis to improving academic skills as well as vocational skills. Mobile units that contained vocational skill training equipment visited the schools with large numbers of migrant students.[50]

The mobile units are models of actual occupational areas and also contain individual study carrels, audio visual equipment, and a small library. Four available areas of training are: auto mechanics, care of hospital and nursing home patients, clerking in supermarkets, and hospital or hotel housekeeping.[51]

The most important feature of this program is that it is serving 14-to 17-year-old youths whose educational needs are not frequently served. The stipend incentive is an important component for children needing to help support their families.

The New York State Migrant Center at the State University College of New York at Geneseo provides a comprehensive program for migrants of all ages, new-born to adult. The several programs are operated at the campus, which is close to several migrant camps. The first program, begun in 1966, was a summer workshop for migrant teachers. This first gathering began an extensive migrant library and designed the program of research and development to improve the education and welfare of migrant children.[52] Since that time several innovative services have evolved for working with this population. One of the first was the Children's Demonstration School, begun in 1967, which served 20 Chicano and Black children. The hours match those of the parents' working hours. Individualized instruction and career education are provided by the teachers, aides, workshop participants, and volunteers from the community. This program has grown in size from the original 20 children to, in 1973, 140 children of Chicano, Black, Puerto Rican, White, and Indian descent.[53] In order to keep the maximum attendance, a Child Development Center for infants and preschoolers also was created so that the older siblings did not have to stay out of school to care for them. This project has been funded by the New York State Department of Agriculture and Markets.

A Teenage In-Camp Program is run primarily for the older children who have been needed to work in the fields during the day. The teachers from the school go out to the camps three nights a week and work with the families.

A weekend program is also sponsored which brings the families to campus every Sunday. Seventy-five to 150 migrants are brought to participate in sporting activities, watch sports events and take a variety of field trips in the region. Parental involvement in the programs also is built in during the week by inviting them to participate whenever the weather is bad and keeps them out of the fields.

Another program at Geneseo is an Aide Training Program for migrants. This is based on a similar premise to Mini-Corps, that "migrants are ideally equipped to communicate with migrants."[54] It also allows more contact of Geneseo staff persons with the families in the area while allowing the migrants to learn valuable skills.

Thus, a comprehensive program involving research, demonstration and, most of all, service for the particular and unique needs of the migrant family has been demonstrated at Geneseo.

Strides are being taken toward making education as accessible and appropriate for migrant children as for children who are not educationally deprived. The magnitude of their unique problems makes special funding and the development of new programs tailored to their situation of utmost importance. However, educating state and local service providers concerning the needs of migrant children is a key part in aiding them. Without state and local advocacy, high quality, sensitive programs will not be provided. In addition, the federal government must monitor and evaluate its own programs to ensure that their goals are being met.

CHAPTER IV

DAY CARE AND PRESCHOOL SERVICES

There is no population more in need of care for their preschool-aged children than migrant farmworkers. Most family members who are old enough must work to supplement the family income. Unless day care of some kind is available, young children and infants are left unattended in the fields, alone in the camps, or in the minimal care of older siblings.[1] This is insufficient to ensure their safety, health, and well-being. At least one estimate holds that over 80% of migrant mothers work;[2] if forced to stay in the camps to care for the children this means a significant decrease in family income resulting in less food and other necessary items for the family.

Several states have documented the need for migrant day care.[3] In addition, a study[4] last year found that 80% of questionnaire respondents nationwide, most of whom were migrant service providers, indicated that day care for migrant children was provided in their area. However, over 40% of these indicated that an extensive unmet need still existed. Respondents also listed day care as the supportive service most needed and of greatest benefit to migrant farmworkers. In view of the poor nutritional and environmental health of migrant children, it is no wonder that day care services are in such great demand. Also, considering the importance to children's physical, emotional, and intellectual development during the first few years of life, early childhood programs for this population are essential.

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Day care is one service that benefits the entire family. It frees the parents to work without worry or concern over the safety of their children, it allows older children to attend school or work without the great responsibility of caring for a young child, and most of all the day care center can provide comprehensive care and help to maximize the development of preschool-age children. Health and nutrition can be provided through well balanced meals and snacks obtainable from the USDA food programs. Also, physical and dental examinations by nurses and local physicians can help prevent serious and infectious diseases. It is important that these initial efforts toward physical health be assured in order to foster intellectual development and well-being. These efforts can also prevent major state educational and social expenditures in the future.[5]

While many programs for young children are custodial in nature, many others provide educational programs which include parental involvement, culturally appropriate programs, and staff development and training so that care for each individual child's happiness, security, and comfort is assured. Custodial care, while better than leaving children virtually unattended, simply provides supervision, shelter and other basic needs. A sensitive and educational program makes certain that nutritional health needs are met along with providing a wide range of experiences appropriate for each age group. These experiences are designed to develop large and fine motor skills, language, social skills, cooperative play, concept formation, attention span and other pre-academic skills that will be a foundation for later learning. In addition, a cultural program may be designed to aid in continuity between home and the child care center.[6] For the migrant family in-stream, this continuity often provides a social life for the family that the local, resident community, often of a different culture than the migrants, can not provide. In many cases this bicultural program necessitates bilingual staff to communicate with children and parents of non-English-speaking backgrounds to make them more comfortable in their new environment and to better understand their needs. This communication with parents and their involvement in center programs helps parents learn skills and activities to use at home with their children. It also gives parents a voice in the decision-making process concerning their children's daily activities. Many programs can also offer employment to parents as teachers' aides in the classroom, thus giving them experience they can use when moving to another area.[7]

Migrants are not the only people in need of day care services. There is a greater demand for day care as more women nationwide are entering the labor force. There are only one million licensed slots available for six million children under six years old whose mothers work.[8] Surely many of the five million remaining children do receive day care through unlicensed arrangements, with neighbors and relatives. Nonetheless, there is a great need to make more licensed slots available, especially for those children left unattended or in the care of older siblings. This need in the general population means that when migrant families move to a new area the number of slots available for their children in already established day care centers in the community is very limited and frequently there is no more room for new children.

Many of these community-based centers are not willing to take migrant children into the same centers as local children because they do not accept migrants as their responsibility due to their transiency and cultural and racial differences. However, the provision of day care is beneficial for community residents and migrant employers as well as for the farmworkers' families. This was shown in a 1973 study by the Michigan Department of Social Services.[9] It was found that the availability of infant care did increase the labor force participation of family members, especially the mothers. Of great importance is the increase in family earnings found as a result of using day care. Those using day care worked on the average of 1.5 weeks more than those not using day care. Families using infant day care earned $330 to $450 more while in the state of Michigan. Other benefits noted in the study included additional earnings for growers and the state economy. Children enrolled in child care programs also received better health care which may diminish the spread of communicable diseases in the area.

Migrants have additional problems in obtaining adequate day care services. Many programs not specifically for migrants, have hours that do not correspond to the parents working hours. If a center runs from 9 A.M. to 5 P.M. this does not adequately serve migrant families who may work from 6 A.M. to 6 P.M. because someone must then stay with the children early in the morning and leave work early to be with them in the afternoon. Transportation has also been a problem for migrant families. Living in rural areas they frequently are very far from local community child care centers and the drive to the child care center is time-consuming, even if a family has its own car or truck. Unless a center has its own form of transportation service many families could not participate. With centers providing transportation, appropriate safety precautions must be taken. When being driven by bus or car, the child is in more danger than at any other time of the day. Toddlers are often sitting unrestrained while infants lie in plastic infant seats not meant for car or bus use; they are frequently in cardboard boxes or an adult's lap.[10] Funding for transporting children safely between the migrant camp and day care center is essential especially since the cost of insurance for transporting children is very high.

A major factor blocking the provision of day care for migrant children as well as other children is the extreme cost. Day care for young children is expensive and for infants it is even more costly. This is due to a variety of factors including the Federal Interagency Day Care Requirements (FIDCR), licensing regulations, and general expenses for diapers, bottles, cots, and other necessary items for the care of young children. A good educational day care program for infants and toddlers may cost as much as $8 to $10 per child per day, or $50 per child per week.[11] This includes enough competent staff members, play materials, and extra programs to enhance the children's experiences. The actual cost of day care programs varies from state to state and may range from $3.00 a day per child to $7.00 a day per child. Sometimes there are wide variations in the public funds day care centers within a single town are receiving. Depending on personal contacts, negotiating skills and the population the program serves, centers may receive different amounts for identical programs.[12]

Being able to hire the required number of staff can be a great expense but is important for the supervision of the children. There is currently an investigation by H.E.W. of the FIDCR staff-child ratio requirements to determine their appropriateness. Currently, the ratios which apply to family day care homes and day care centers funded by federal dollars are: 0-6 weeks - 1:1, 6-36 months - 1:4, 3 years - 1:5, 4-5 years - 1:7, 6-9 years - 1:15, 10-14 years - 1:20. The results of the appropriateness study mandated by Congress will be available sometime in 1977 in order to establish the final criteria for staff-child ratios and other FIDCR requirements. This may significantly affect the amount and quality of day care available to all children.

Licensing of buildings which house child care centers also affects provision of services, especially in rural areas. School buildings are often available for programs in the summer months. However, when school reopens in the fall, the programs must frequently end regardless of whether there are still children in need of day care. Many other buildings which would meet the licensing requirements are not available. Churches are frequently used when they can meet the state standards and a group is willing to sponsor a program. With the migrant population, day care centers which service them are, in many cases, only temporary (for a few months of the year). It can be difficult to find a facility for only the necessary times and still have it utilized the remainder of the year. Otherwise it is not economically feasible to maintain a building which is empty for most of the year. Also, even if one is found, it is hard to justify the expense of modifying the facilites to meet licensing requirements for only a few months use.

A variety of forms of day care are available to the migrant parent. The greatest number of slots that can be used by migrant children is by far in group child care centers. These may be operated by private organizations for profit, or nonprofit organizations such as church councils, migrant ministries or farmworker organizations. Family day care homes (generally able to serve up to 6 children), group day care homes (generally able to serve up to 12 children), and day care aides in the camps are available although in smaller numbers. Some of the centers may be run specifically for the migrant population while others are community-based and a few slots, if available, may be purchased for migrant children when they enter the community.

MAJOR FEDERAL LEGISLATION AND PROGRAMS RELATING TO MIGRANT DAY CARE

Federal funding is the major source of support for these various kinds of day care available to migrants. Only a few states, such as New York and California, provide state funds for migrant day care. This, however, is an unusual funding situation.

Social Security Act, Title XX - Grants to States for Services

Title XX is the major federal funding source for the provision of day care and other social services to eligible citizens of the state as determined by each state. It became effective October 1, 1975 for the purpose of allowing states more control over how social services are to be provided with state-federal matching funds. The Act is meant to encourage states "to furnish services directed at the goal of-

1. achieving or maintaining economic self-support to prevent, reduce, or eliminate dependency,

2. achieving or maintaining self-sufficiency, including reduction or prevention of dependency,

3. preventing or remedying neglect, abuse, or exploitation of children and adults unable to protect their own interests, or preserving, rehabilitating or reuniting families,

4. preventing or reducing inappropriate institutional care by providing for community-based care, home-based care, or other forms of less intensive care, or

5. securing referral or admission for institutional care when other forms of care are not appropriate, or providing services to individuals in institutions."[13]

One of the services directed at these goals may be child care at state option. For the purpose of providing child care and other services covered under the Act such as foster care, protective services, and transportation, each state submits a Comprehensive Annual Services Plan (CASP) to the Social and Rehabilitative Service (SRS) in the Department of Health, Education and Welfare. The plan is developed by the designated Title XX agency in cooperation with local Title XX agencies, other public or private agencies, organizations and individuals. It must undergo a public review process before submission to SRS. If the CASP meets the requirements of the law, the state is then entitled to reimbursement for eligible expenditures for for social services on a 25% - 75% state-federal matching basis for most services.

Much criticism has been levied against various aspects of Title XX since its inception. While the greater state decision making and more voice in service provision has been welcome, stringent regulations have caused administrative problems in most states.[14] The review process is complicated and, since the Act attempts to keep spending down, there is great competition for funds.[15] Unless groups with particular concerns, such as migrant advocates, assert their views, there is little hope of getting funds. Migrants, with little constituency and voting power, are at a significant disadvantage in this respect. Most Title XX day care criticism has been concerned with the stringent FIDCR requirements. Many states, until the current suspension of the requirements pending further study, struggled to enforce FIDCR requirements and found a resulting increase in per capita cost for day care. Many centers feared that they must close rather than pass the cost on to the families or meet the additional cost themselves.[16]

Income eligibility criteria have also created problems in the states. The determination of client eligibility requires documentation of income, however, a state can option to use a declaration method of determining eligibility. If they do not, clients must complete extensive applications and present documentation of each income source in the form of check stubs, bank statements, etc. Criticisms of this extensive verification system are that it is degrading to the clients and delays service to them, as well as being administratively costly. Recently, however, an amendment to Title XX in September 1976, approved the use of group eligibility for child day care services for migrant agricultural workers. This means that, at state option, all persons who are migrants are eligible to receive day care services without individual determinations of eligibility. It is assumed that all members of this "group" would be income eligible. This amendment, therefore, greatly increases the ease with which migrant families can utilize day care services funded by Title XX, although state approval must first be obtained.

Title XX services may be provided by private, non-private organizations under contract to the Title XX agency in each state. Funding is provided to group child care centers for migrants and local children, family day care homes and day care aides in the camps. However, it is up to a sponsoring agency, such as a farmworker organization, which is interested in migrant welfare to document the need for services to migrants and offer resources for provision of these services. Additionally, the need is so great for migrant services that several agencies at the local level would have to apply for funds in order to meet the great need for migrant day care. Eligible migrant children can be served in local centers funded by Title XX. In addition, Title XX funds are usually paid only as reimbursements, not always in advance of expenditures. In most states start-up funds are not provided which requires the sponsor to carry significant start-up expenses before being reimbursed. Few community organizations can cover these costs. Title XX is a major source of migrant day care funds, and due to group eligibility it should now be relatively easy for migrants to utilize. It is also applicable to a variety of types of day care. Other sources of funds for these services also exist, however, and these are described below.

Migrant Head Start

The Head Start program began in 1965, and is authorized by the Economic Opportunity and Community Partnership Act of 1974. It was funded to provide quality preschool services and enhance the development of preschool children from low-income families. Migrant Head Start is designed to provide full preschool services tailored to meet the needs of migrant families. It is administered by the Indian and Migrant Programs Division (IMPD) of the Office of Child Development of the Department of Health, Education and Welfare. Fourteen migrant grantees around the country receive funding to provide services at the local level. For example, the East Coast Migrant Project serves nine eastern stream states, the Texas Migrant Council serves ten states, and the Illinois Department of Children and Family Services operates centers in Illinois. However, a relatively small number of migrant children are served nationwide. Federal funds provide up to 80% of the total grant, making migrant head start centers responsible for mobilizing at least 20% for the non-federal share. Waivers of this requirement may be given in certain substantiated cases for centers unable to raise the money from other sources.

The target population to be served by Migrant Head Start is the truly mobile migrant. Seasonal workers or settled-out migrants are only served if they can be easily incorporated into the program. Eligibility is then determined by income and tuition is paid according to a fee schedule based on the family income. Furthermore, 10% of the children served must be handicapped. Unlike "regular" Head Start, care is provided for children from infancy through five years of age since migrant parents need infant care in order to be free to work.

The Migrant Head Start program provides a comprehensive range of services including health care, nutrition, social services such as outreach and referral, and parent involvement. The center's hours must match the parents' field hours and transportation must be available early enough so as not to delay the parents' working. Many centers begin as early as 4 A.M. and run as late as 10 or 11 P.M. to accomodate unusually long or staggered work hours. In addition, it is important that the center be open from the beginning of the season until the last workers leave the area. A continuous enrollment policy assures that children arriving later in the season may still enroll at the center.

Health care, in the form of physical and dental examinations and treatment is provided. Nutritional services include breakfast, lunch and two snacks in extended day programs. The food service programs administered by the U.S.Department of Agriculture are utilized in the Migrant Head Start centers and have been since 1969.[17]

Bilingual/bicultural programs and teachers are available in centers where the population served is Spanish-speaking.

Parent involvement is recognized as an important aspect of the center's program. However, it is also recognized that it is often very difficult to incorporate the parent's participation while in-stream, due to their work schedule and tiring days. To compensate for this, the involvement of older siblings is encouraged in a substitute capacity. Also, home base centers try to emphasize this aspect since it may be easier for parents to participate there rather than in-stream.[18]

Two categories of programs, local and national, are funded by Migrant Head Start. The nature of the national programs allows continuity of services while the local programs do not. Local programs, located in the local communities but available to migrant children when they enter the area, are either "traditional" or "catered." In the traditional model, no special provisions are made for migrant children. Therefore, it is the least desirable of the models and very few children for short periods of time are served in these centers.[19] The catered local program does have special services for migrants. Hours are extended, infants may be enrolled and bilingual/bicultural staff is provided where applicable. However, these programs are unable to provide continuity of services when the children leave. The long-range effectiveness of the local models is questionable.[20]

The national programs may be organized according to the Prime Grantee Model or the Network Model. The Prime Grantee Model is designed for programs in areas with relatively long seasons, four or five months, in one place. While this service enables families to keep their children enrolled in one center rather than uprooting them every month or so, it has some operational problems. A four to five month program overlaps with the regular school year making personnel recruitment difficult. Many teachers prefer short-term summer employment or full-year employment. Another problem yet to be remedied is that of guaranteeing continuity of services when children return to home base. Health and education records are sent to home base centers, however, by the time the children arrive, the centers may be filled.

The Network model is a mobile program which operates in both in-stream and home base areas. The Texas Migrant Council program is of this type. The program follows the stream and is established in areas of high migrant concentration. This allows great flexibility since staff can be regrouped as the migrant population increases or decreases during the season. Additionally, it is a year-round program which facilitates recruitment. The centers are as similar as possible for maximum continuity and it is the most effective of the models provided.[21]

Migrant Head Start is designed to provide maximum utilization by the families, provide infant care where few other programs do, and incorporate a comprehensive range of support services. It is, however, reaching a fairly small number of migrant children. In 1974, 4100 children were served and with additional funds 3,200 more were served. This was increased to 5,454 migrant children in 1976, with the total funding level at almost $5 million dollars. This still equals less than one percent (1%) of the estimated migrant child population.[22]

Elementary and Secondary Education Act (ESEA), Title I Migrant

As described in the previous chapter, this is the major funding source of migrant education programs. Day care for preschool-age children can be funded in certain instances, although children under five do not add to the local funding entitlement. As a result, a school must use the funds it has available for its school-age children to serve preschool children, if it so chooses. In the Title I migrant summer program, children ages three to five, as well as school-age children, can participate. Care for children under three years may be provided if it enables older siblings to attend school, if it is not available from other public or private agencies, and if it is not "extravagant" and does not detract from the program for school-age children. In the event that day care is necessary, a center may be established, if enough funds are available, or slots may be purchased in already established centers and homes, or day care aides can be funded to provide in-camp care. In

1976/1977, a total of 37,930 children between the ages of one and five were served by Title I migrant.

Comprehensive Employment and Training Act (CETA), Title III-B

CETA is also described in the previous chapter concerning educational programs. While the main purpose of the Act is manpower training for migrant and seasonal farmworkers, CETA also provides funds for supportive services for manpower trainees and to assist those remaining in migrant and seasonal farmwork. Most services, however, are reserved for enrollees in manpower service programs. Lack of funds and administrative time has made it hard to provide services to more non-enrollees.[23]

One of the supportive services provided is child care. A few CETA programs operate their own day care centers, but most often slots are purchased in other centers. Often farmworker organizations in various states are CETA grantees and operate the local child care programs. In the Northwest, one program operates nine centers and serves 450 children.[24] In California, a program operates five centers under CETA and four under Migrant Head Start.

Child care for migrant families is perhaps the service they need most. It frees the parents to work without concern for their children's well-being while keeping the children out of hazardous work areas. Services for child health, nutrition and education are often provided in day care centers, and, as in Migrant Head Start and Title I Migrant, continuity of services while in-stream and home based has aided children by beginning to compensate for their mobility. While day care, especially infant care, is relatively costly, it may prevent future health and educational costs as well as assuring the child's happiness. High quality early childhood care can have perhaps the greatest impact on any child's future life, especially that of the disadvantaged child.

CHAPTER V

ISSUES RELATED TO MIGRANT CHILD WELFARE

Child Abuse and Neglect

The issue of child abuse and neglect has become a national concern in the last few years. The National Center for Child Abuse and Neglect (NCCAN) was recently established in the Children's Bureau of H.E.W.'s Office of Child Development. This Center was established in 1974 by the Child Abuse Prevention and Treatment Act. Its purpose is to assist state, local and voluntary agencies to prevent, identify, and treat child abuse and neglect. Additionally, the center serves as an information clearinghouse and attempts to increase public awareness of child abuse and neglect. In 1976, approximately 18 million dollars in research, development and training grants were allotted to strengthen protective services for children. NCCAN has also established fourteen resource centers around the country to provide technical assistance to child abuse and neglect service personnel. Along with NCCAN, all other federal agencies concerned with child abuse and neglect have formed a Child Abuse Advisory Board for better coordination of services and to resolve any duplication of effort in this area. This new effort at the federal level is reflective of a growing awareness of the extent of child abuse in our society.

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Child abuse and neglect has been variously defined and perceptions of the problem have changed over the years. Generally, child abuse and neglect has been defined as physical or psychological harm to the child as a result of acts of violence or inadequate support of the child in health, nutrition, clothing, shelter, or emotional care. In considering this definition and the problems inherent in the migrant farmworker's lifestyle, it is evident that migrant farmworkers, adults as well as children, suffer from inadequate access to care in these areas.[1] Migrant children living in this environment, suffer from what may be called a "situational" neglect that is a condition of the migrant farmworker's livelihood. Their low socio-economic status has not allowed them to adequately provide sufficient care for their children in health, nutrition, clothing, shelter or psychological support. This type of neglect, while not deliberate may, nonetheless, have serious effects on the child.

There are no data available on the actual incidence of child abuse in the migrant population or in the general population. The unique characteristics of the migrant farmworker's lifestyle, such as constant migrating, also make it especially difficult to document cases of abuse or neglect. One might assume, however, that it exists in the migrant stream, to some degree, since it exists in the general population. The extent of child abuse and neglect has been roughly estimated to be between 60,000 and 500,000 cases per year.[2] And according to the American Humane Association's Clearinghouse on Child Abuse and Neglect, approximately 2,000 deaths can be attributed to maltreatment each year.[3]

Several studies have indicated that parents who abuse their children have several family characteristics in common which, if present, may form a "high-risk" group. Some of these characteristics are evident, to a great extent, in the migrant population. However, there are also strong factors present which would contribute to family stability and support. Recently, a University of North Carolina research team interviewed the parents of 140 infants and found common characteristics present in parents who later abused their children. These included serious financial problems in 70% of the cases, and inadequate child care arrangements in 65% of the cases. Both of these certainly reflect the migrant farmworkers' situation.[4]

Other studies have sought to determine what particular environmental situations contribute to the existence of child abuse and neglect. Sattin and Miller (1971) found abuse to be more prevalent in areas of greater poverty, higher crime rates, lower quality housing, and transient populations which contribute to environmental stress. Another study in 1970 cited degree of isolation, level of environmental stress, and the amount of support and resources available as contributing to abuse and neglect. These characteristics also parallel the migrant farmworker's situation. Thus, while no documentation of child abuse and neglect exists, the migrant family and environment do have several characteristics in common with what researchers have described as high-risk groups.

Other characteristics of the migrant culture, however, make the migrant farmworker an unlikely candidate for child abuse and neglect. In particular, the extended family, characteristic of much of the migrant culture, is a built-in support system for family members. The family is usually very close and interested in the welfare of its members. The migrant community itself is often a close-knit society with supportive friends and neighbors. This family structure and close community relationship may certainly have a positive effect on the incidence of child abuse and neglect. Only the collection of reliable data will begin to show if there is child abuse, and how much, in the migrant stream.

One of the major problems in gathering accurate data on the extent of child abuse and neglect has been the lack of adequate reporting. This is a great obstacle to prevention and remediation of child abuse and neglect.[5] Recent innovations to increase the level of reporting have included the use of 24-hour "hotlines" in many communities. These lines typically operate by putting the parent in touch with a social worker or someone who may help to get them through a difficult time rather than abusing, or continuing to abuse, their child. This system is not as accessible to the migrant population, however, since few migrant farmworkers have access to a telephone, especially at late hours. In addition, while in-stream many do not have trust in the local public social service agencies.

Public awareness campaigns at the federal and state levels are also attempting to improve reporting of child abuse cases. The State of Florida began an intensive public information campaign in September 1972. Radio and television advertising was coupled with the use of a "hotline." After 12 months, it was found that the total number of reports statewide had increased 55% over the previous year.[6] It is highly unlikely that such a dramatic increase in reporting within one year could be due to an increase in the number of incidents of child abuse and neglect. It is more likely that the reports were based on pre-existing conditions.[7] But, unless outreach into the migrant camps and work areas is provided, radio, television and billboard advertising will not reach the migrant community.

Parents Anonymous is another recent intervention program for child abuse and neglect. Its purpose is to be a preventive, self-help organization. It was founded by a former abusing mother, in Los Angeles, in 1969. The organizations now exists in other communities around the country.[8] Parents Anonymous depends on contact with other parents, especially in times of stress, through frequent meetings and by telephone. This, however, is a community-based program and migrant families have limited contact with the local communities while in-stream. Again, telephones are not usually available and in many cases the migrant parents do not speak English. Unless a similar group was formed within the migrant community, this program would be of limited help.

The use of central registries for cases of child abuse and neglect has been implemented in almost every state and the District of Columbia mostly within the last eight years. These registries provide a comprehensive index of cases of child abuse and neglect to serve all concerned agencies and medical facilities where a child is likely to be taken for treatment. The function of the registries differs from state to state, however. In Indiana, the registry merely collects statistical reports from the county, while in New York it is used for research, policy planning, diagnosis, monitoring and coordination. Also, in some states the registry consists only of a set of index cards to record a case, while other states have more elaborate electronic processing systems.[9] At its best the registry is a mechanism that can be useful as an aid to diagnosis and intervention. But at present the central registry system is, in most cases, unused, unusable, and inaccurate.[10] The data registered is frequently incomplete and out-of-date and no follow-up data is provided so that protective service personnel know what procedures have already been used to remediate the problem. Additionally, the system is inefficient in many cases requiring that requests for information be mailed and even responding to them by mail. This is far too time-consuming to be helpful in severe situations. Regular business hours are often maintained which further decreases its usefulness for crises occurring during the evenings.[11] Furthermore, caution must be taken to ensure confidentiality and to guard against the damage which could be caused by erroneous information.[12]

The purpose of the central registry is a useful one if it is perfected. Abusing parents often take their child to different hospitals for treatment in order to avoid suspicion.[13] Consequently, no adequate medical history is available to the attending physician unless a central, comprehensive system can be utilized. As regards the migrant population it would be particularly useful since the system could help offset the lack of continuity of services they encounter while in-stream.

Perhaps what is needed most to remedy child abuse and neglect is the remediation of problems in health, nutrition, housing and child care arrangements. This approach, through primary prevention, includes social service outreach programs, accessible health clinics with nutrition programs and family planning programs to prevent unwanted pregnancies. Day care ideally offers social stimulation to the children of isolated families and relief from the burdens of child care for parents.[14] The use of homemaker services, frequently provided through the local departments of social services, may also be an appropriate form of intervention. This service provides someone to come into the home and help out with daily chores while educating the parents in ways to cope with child care and household duties.

The availability of an advocacy group, such as a farmworker organization, that the family can turn to in a variety of problem situations may also be beneficial in alleviating environmental stress. The Texas Migrant Council (TMC) is one such agency that is currently conducting a Child Abuse and Neglect Prevention Program. The project was funded by the National Center for Child Abuse and Neglect for three years beginning in 1975. This is a mobile child abuse project in which caseworkers travel to the northern worksites to which previously identified Texas families migrate.[15] Caseworkers usually follow a case, providing continuity of service in-stream. By working with the migrant community, TMC hopes to educate the migrant families that agencies are not always punitive but can be helpful to them. TMC also hopes to improve local agencies' awareness of the migrant situation. A network of communication and coordination within the state and between states can then be established to help migrant families.

The philosophy of the TMC project is to use the strong characteristics of the migrant family to help alleviate problems. Concepts used in the program are: 1)use of the extended family in child placement, treatment and counseling reinforcement; 2)provision of continuity of services between home base and in-stream states; 3)provision of needed medical and therapeutic services; 4)complementing and acting as a referral agency for state mandated child abuse and neglect agencies; and 5)becoming a resource for state protective service agencies.

The need for gathering reliable data on the incidence of child abuse and neglect is beginning to be recognized. These data can help to define the characteristics of high-risk groups which will help in remediating the problem by attacking the conditions contributing to it.

Legal Matters of Concern to the Migrant Farmworker

Throughout the preceding chapters, many cases have been cited in which migrant farmworkers have either been excluded from protective legislation or abuses have occurred in enforcing legislation which would improve migrant living conditions. Lack of OSHA enforcement and the exclusion of migrants from most worker's compensation laws are just two examples of discriminatory applications of laws adversely affecting migrant farmworkers. Not only has there been disobedience to legislative and judicial decisions and discriminatory enforcement, but the domination of special interest groups has contributed to the discriminatory nature of the laws themselves.[16]

One authority has listed three conditions which lead to these breakdowns in legislative protection: 1)the victims are without access to the legal process; 2)official action affecting them is not subject to public scrutiny and review; and 3)there has been no clear delineation of public policy with respect to them.[17] All of these factors define the political condition of the migrant farmworker.

While legal support is not a service which directly affects the immediate physical and psychological needs evident in migrant child welfare, legal aid does have long-range impact on the entire migrant population. The scope of these problems affects all areas of migrant life, including nutrition, education, and the level of wages earned by the family. According to Vice-President (then Senator) Walter Mondale: "Running all through the problems of the migrant ... is the fact that they are so impotent politically that there is no requirement, no need, to respond to their legitimate requests.[18] Migrant child welfare is inevitably dependent upon, and inseparable from the political condition of the whole migrant farmworker population.

Beginning in the early 1970's, the legal needs of migrant farmworkers began to be recognized. The Office of Economic Opportunity (OEO) funded Rural Legal Service programs. Some of these programs were faced with opposition from local Bar Associations, who frequently ran their own programs. Even with both in operation in some places, however, access to legal aid was still limited.[19] Many workers who filed complaints or tried to organize were fired. With the demise of OEO, the Legal Services Corporation took over the Rural Legal Service programs. Full-time farmworker-oriented programs are sponsored which provide outreach, and specialize in farmworker problems. These programs have been generally successful.[20] Twelve programs are now operating either independently or as Legal Services Corporation grantees. One of the major grantees is the Migrant Legal Action Program (MLAP).

As with other services, the nature of the migrants' lifestyle prevents migrants from taking full advantage of legal services. The legal process takes a long time and the migrants may be gone before a case even goes to court. Furthermore, it may be months or years before the effect of the decision is seen.[21]

Decisions in Florida, Pennsylvania and New Jersey have provided legal protection for migrants against involuntary servitude by their crew leaders, and provided for the right of access to migrant camps. One of the most recent cases affecting migrants has received national attention. This case was the decision by Judge Charles R. Richey in NAACP vs. Brennan. In 1972, sixteen farmworkers and public interest organizations and 398 individuals accused the Department of Labor (headed by Secretary Peter Brennan) of discrimination and exploitation of migrant farmworkers. More specifically, the complaint accused the Rural Manpower Services of State Employment Services of not giving farmworkers the full range of benefits to which all citizens who use the Employment Services are entitled. As a result, Judge Richey, of the U.S. District Court, ordered the Employment Services to offer all the services of counseling, testing, and job referral equitably to farmworkers and non-farmworkers alike, to end discrimination against farmworkers. This order has become known as the "13 point plan," after the specific requirements that must be met by each state's program. DOL was also directed in this plan to establish an effective complaint and monitoring system to ensure compliance with the order. It was not until 1975, however, that DOL transmitted a complete set of guidelines to the state and local employment offices for implementing the order. Judge Richey also established, in his order, a Special Review Committee composed of seven plaintiffs and defendants. In addition to the Committee, a "monitor/advocate" was established in each state and region to ensure compliance and report to the Committee.

The Review Committee, throughout 1976, held hearings in various states to determine the extent of compliance and non-compliance in those states. The results were not encouraging. A report in April stated that ten states were significantly out of compliance on several points.[22] Overnight reform was not anticipated, and some improvements have been made, however, the Committee found little to suggest that the government was taking decisive action. For example, in Colorado, Spanish-speaking migrants were routinely refused assistance by the Employment Service.[23] The final report has been submitted to Judge Richey and he must decide what system of accountability should be applied to assure migrant and seasonal farmworkers their rights.

Another legal issue currently receiving national attention is concerned with the existence of undocumented workers, or illegal aliens. There is no accurate estimate of just how many people are working illegally in this country. It is known, however, that a great many, nearly one-half of the apprehensions made by the Immigration and Naturalization Service (INS) in 1972, had been employed in agricultural work.[24] A large number of undocumented workers are concentrated in the Southwestern United States near the Mexican border, which is also the home base for many Mexican American migrants. It is in this area that a great many illegal aliens have settled and gone to work. The majority of them are from Mexico while others are from any of a large number of developing countries with growing populations and high rates of unemployment.

These workers cross the border as economic refugees looking for employment. Many employers, nationwide, seek out undocumented workers because they can pay them less. A pool of cheap labor is created due to the great economic needs of these families. This depresses the labor market and leads to the exploitation of undocumented workers.

Employment conditions for this population are much worse than for other workers.[25] Wages are lower and housing conditions are among the worst. Furthermore, they can not protect themselves or bargain with employers or crew leaders for fear of drawing attention to their illegal status. Many employers have been known to notify authorities of the whereabouts of illegals they employ after the working season has ended and before the workers are paid.[26] Frequently, these employers are not prosecuted since no federal law has been technically violated.

Low-income American families are affected the most by the competition for jobs with undocumented workers. A recent study by the Domestic Council Committee on Illegal Aliens also found that low-income families were adversely affected by strains put on health and welfare services and public schools.[27] While it is certainly profitable for employers to hire undocumented workers, (which, in turn, may lower prices and thereby benefit residents), it is the legal unskilled or low-income workers who lose from the presence of illegals.[28]

The question of what to do about this situation raises some important issues for legal Mexican Americans. The difficulty in picking out illegal alien workers from the domestic work force makes law enforcement problematic.[29] Many times "dragnet" raids are conducted by the Immigration and Naturalization Service. Workers are frequently picked up only on the basis of appearance, clearly violating the rights of many American workers who then must prove their citizenship. Random car checks and raids have led to harrassment and even the arrest of legal citizens.[30]

Additionally, pressure not to hire undocumented workers, rather than resulting in the establishment of rigorous screening procedures, may result in the curtailment of the employment of legal Mexican Americans.

Legislation dealing with the problem of undocumented workers is currently under review by Congress, and INS is continuing to gather more data for further investigations. Whether or not the problem is resolved in any way, the presence of undocumented workers affects the employment and wages of legal migrant agricultural workers and puts stress on needed welfare services. Regardless, the discriminatory law enforcement procedures also work to the detriment of American citizens. Some practical solutions have been suggested which call for tighter border control, with entry quotas geared to labor market needs and, efforts to legalize the status of illegals already here in lieu of frequent and expensive deportations.[31]

CONCLUSION

The labor of migrant farmworkers contributes substantially to the economic welfare of the counties where they work and to the agricultural productivity of the nation as a whole. Yet, the majority of migrant families are underpaid, overworked, educationally deprived and suffer from malnutrition and other health problems. Hundreds of thousands of migrant children share these deplorable conditions with their farmworker parents and no aspect of their lives is left untouched.

Most people at the local, state, and federal levels have refused to take responsibility for extending to these families the same rights and privileges enjoyed by other American citizens. The delivery of services to migrant farmworkers is inhibited by many barriers -- language, mobility, and discrimination. These barriers create a need for special programs and regulations which respond to the unique needs of migrant farmworkers. At present, many laws which benefit the general population do not meet the migrants' needs. In the case of laws governing federal programs designed specifically for migrants, full compliance is all too rare.

The magnitude of these problems and the large number of children affected demand a concerted effort to provide support to migrant families through supplemental child welfare services such as day care, health programs, and adequate education. The provision of these types of services not only alleviates immediate child welfare problems but also constitutes preventive care which, in the long run, is the only means to provide hope and a future for migrant children.

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